

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) Mable J. Buford.					2a. DATE OF DEATH MONTH DAY YEAR Nov 27-1982		2b. HOUR 11:45 AM		
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR May 19 1904		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.			
10. CITY OR TOWN OF DEATH Manchester		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Long View Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House wife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD.		13b. COUNTY Carroll		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2212 Capehorn Rd.			
14. FATHER'S NAME FIRST MIDDLE LAST Augustus Schulz					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary S. Haler				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 481-09-6354		17. INFORMANT ADDRESS Hampstead, MD. 21074 David Buford - 2212 Capehorn Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs 5 yr.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Leukemia secondary to dechitisulcers 3/ Renal Insufficiency									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Sept 11-30 1982 to Nov 27 1982 , that (I) (we) last saw the deceased alive on 11-30 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE W. H. Howard M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 11/27/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. H. Howard M.D.		22e. ADDRESS 3223 Main St Manchester Md 21102							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-30-82		23c. NAME OF CEMETERY OR CREMATORY Hampstead Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hampstead Carroll Md.			
24. FUNERAL DIRECTOR NAME Eline Funeral Home, Hampstead, Md. 21074				25a. DATE REC'D. BY REGISTRAR NOV 30 1982		25b. REGISTRAR'S SIGNATURE John J. Connel			

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Handwritten text: *Handwritten text, possibly a signature or date, is visible but illegible.*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office of the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH-16 30M 2/80
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 9 2 1 3			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EMMA REBECCA BABEL				2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 7, 1982		2b. HOUR 1:35 PM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 3-25-1886		6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.	
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WESTMINSTER NURSING CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SEWING		12b. KIND OF BUSINESS OR INDUSTRY CLOTHING	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STREET ADDRESS 3151 SYKESVILLE ROAD			
13a. STATE MD.		13b. COUNTY CARROLL		13c. CITY OR TOWN WESTMINSTER		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST LEWIS BARNES				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET POOLE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 416-10-9809		17. INFORMANT ADDRESS AUSTIN A. BABEL 13e, 21157			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Cerebral Vascular Accident DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic CV Disease DUE TO, OR AS A CONSEQUENCE OF (c) Chronic brain syndrome						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years	
						Years	
						Years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 11-5, 1979, to 11-7, 1982, that (I) (we) lost saw the deceased alive on 11-7, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE C.E. McWilliams, MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11-7-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C.E. McWilliams				22e. ADDRESS 11909 Kresterton Rd Kresterton Md 21136			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 11-10-82		23c. NAME OF CEMETERY OR CREMATORY MT. PLEASANT		23d. LOCATION CITY OR TOWN COUNTY STATE GAMBER CARROLL MD	
24. FUNERAL DIRECTOR NAME Robert K. B. Priddy Jr. Westminister, Md.				25. DATE REC'D BY REGISTRAR NOV 12 1982		25b. REGISTRAR'S SIGNATURE John J. Smith	

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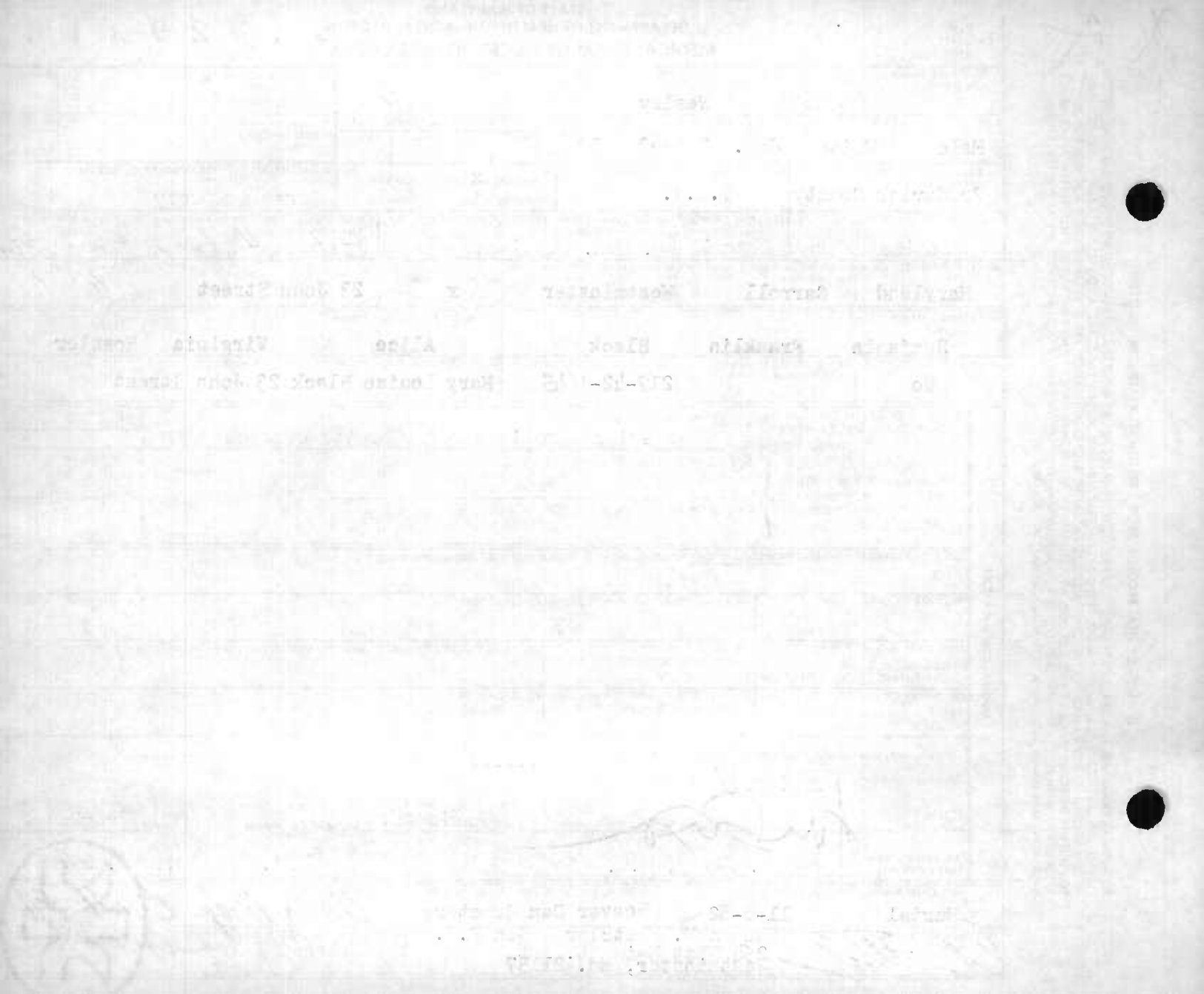
10-10-10

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 9 2 1 4	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN Wesley BLACK Sr.										2a. DATE KNOWN OF DEATH XX MONTH DAY YEAR 11 5 1982	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 7 1943		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 39		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Frederick County				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County	
10. CITY OR TOWN OF DEATH Westminster				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Co. Gen. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING YRS.) State Highway		12b. KIND OF BUSINESS OR INDUSTRY Farming	
13a. STATE Maryland				13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 23 John Street	
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin Franklin Black						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Virginia Hossler					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-42-1645				17. INFORMANT ADDRESS Mary Louise Black 23 John Street			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4292 (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Ann M. Dixon, M.D.				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 11-5-82			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 11-8-82		23c. NAME OF CEMETERY OR CREMATORY Beaver Dam Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Union Bridge Carroll Md.	
24. FUNERAL DIRECTOR Name Thomas D. Fletcher & Son F.H.				25. DATE REC'D. BY REGISTRAR 254 East Main St. Westminster, Md. 21157				26. NOV 9 1982		27. REGISTRAR'S SIGNATURE John J. Smith	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 1 AND 2 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (1))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) STEPHEN Carl BLANK			2a. DATE KNOWN OF DEATH ESTIMATED 11 11 19 82			7b. HOUR M				
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 29, 1958	6. AGE (IN YEARS LAST BIRTHDAY) 24 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD 11 11 19 82			2d. HOUR M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.				
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North of Old Westminster Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic at Service Station		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.			13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 17 Washington La. 21157
14. FATHER'S NAME FIRST MIDDLE LAST Philip E. Blank			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Lynch							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 213-72-7389		17. INFORMANT ADDRESS Mr. Philip E. Blank Reisterstown, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple injuries</u> 8150 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1:08xx 11-11-19 82		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver in auto/fixed object impact.					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		21f. LOCATION STREET CITY OR TOWN COUNTY STATE North of Old Westminster Rd., Carroll Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .										
ACTUAL SIGNATURE 			TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 11-11-82			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.			ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 15, 82		23c. NAME OF CEMETERY OR CREMATORY St. Patrick Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Mt. Savage, Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Eline Funeral Home Reisterstown, Md. 21136					25a. DATE REC'D. BY REGISTRAR NOV 17 1982		25b. REGISTRAR'S SIGNATURE 			



UNIT 11

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report filed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 82 29216			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Joseph Gonso Blizzard				2b. HOUR 12 PM			
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 11 21 1911		6 AGE (IN YEARS LAST BIRTHDAY) 70 YRS. MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Carroll County		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Carroll MD	
10 CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver-overnight		12b. KIND OF BUSINESS OR INDUSTRY Trans.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY Maryland Carroll		13b. CITY OR TOWN Westminster		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 55 Carroll Street 21157	
14 FATHER'S NAME FIRST MIDDLE LAST Jeremiah Blizzard		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lydia Martin		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			
16b. SOCIAL SECURITY NO 215-05-3311		17 INFORMANT ADDRESS Helen Louise Blizzard 55 Carroll Street					
18 CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIOGENIC SHOCK</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACUTE MYOCARDIAL INFARCTION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASAD</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>MINUTES</u> <u>3 DAYS</u> <u>YEARS</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>CARCINOMA LG. LUNG & SEVERE HYPOKEMIA</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/13/82 to 11/13/82 (that (I) (we) last saw the deceased alive on 11/13/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (did) not view the body after death.							
22b. SIGNATURE M. Susan Zollinger				22c. DEGREE MD		22d. DATE SIGNED 11/13/82	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) M. Susan Zollinger				22f. ADDRESS 215 WEA. HGS MED CTR. WESTMINSTER MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-16-82		23c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Finksburg Carroll MD	
24. FUNERAL DIRECTOR Thomas D. Fletcher & Son F.H.		25. ADDRESS 254 East Main Street Westminster, Md. 21157		26. DATE REC'D BY REGISTRAR NOV 18 1982			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 9 2 1 7			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FRANK GARNER CLAY				2a. DATE OF DEATH MONTH 11 DAY 16 YEAR 82		2b. HOUR 2:45 PM	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH June DAY 16 YEAR 1902		6. AGE (IN YEARS LAST BIRTHDAY) 80		IF UNDER 1 YEAR MONTHS DAYS 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Texas		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.	
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Co. General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist		12b. KIND OF BUSINESS OR INDUSTRY Steel	
13a. STATE Md.		13b. COUNTY Carroll		13c. CITY OR TOWN Hampstead		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME Thomas ?		15. MOTHER'S MAIDEN NAME Lillie ?		13e. STREET ADDRESS 2650 Old Fort Schoolhouse Rd.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213 07-8071		17. INFORMANT Carol Clift 2650 Old Fort Schoolhouse Rd. Hampstead, Md. 21074			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute respiratory insufficiency 4960 DUE TO, OR AS A CONSEQUENCE OF: (b) chronic obstructive disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c) 							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) chronic obstructive heart disease							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/15 , 19 82 , to 11/16 , 19 82 , that (I) (we) lost saw the deceased alive on 11/16 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Park W. Espenschaede MD				22c. DATE SIGNED 11/16/82		22d. ADDRESS WESTMINSTER, MD. 21157	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/19/82		23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hampstead Carroll Md.	
24. FUNERAL DIRECTOR H. J. Eckhardt				25a. DATE REC'D. BY REGISTRAR NOV 22 1982			
ADDRESS Manchestee, Md.				REGISTRAR'S SIGNATURE John J. Conner			

BP

1917



Handwritten text, possibly a signature or date, in the middle of the page.

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Handwritten text, possibly a date or a short sentence, in the lower middle section.

Handwritten text, possibly a date or a short sentence, in the lower section.

Handwritten text at the bottom of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

BP _____

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 2 1 8

REG. NO.

1 - FOR
STATE
REGISTRAR

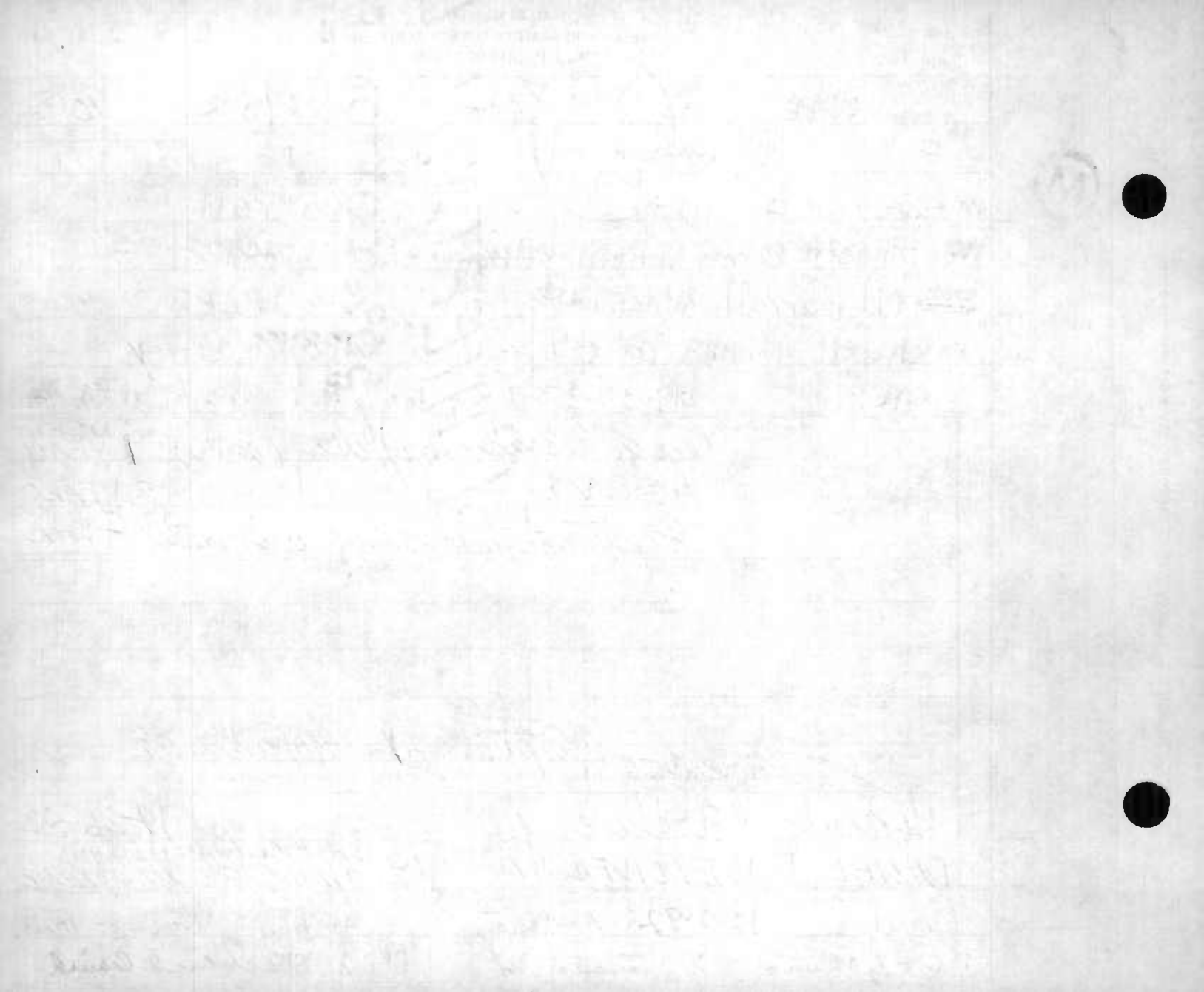
1 DECEASED NAME (TYPE OR PRINT) olive C Cole			2a. DATE OF DEATH MONTH DAY YEAR 11 26 82		2b. HOUR 10 15 AM								
3 SEX F		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 11 14 96		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASSACHUSETTS		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.							
10 CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Lutheran Village circle teacher				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) teacher		12b. KIND OF BUSINESS OR INDUSTRY -					
13a. STATE Md						13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 646 Denton Drive	
14 FATHER'S NAME FIRST MIDDLE LAST michael Thomas Carroll						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie victoire utley							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) unk.				16b. SOCIAL SECURITY NO. 019-34-3557		17 INFORMANT ADDRESS Mrs Arthur Peck Westminster, Md							
18 CAUSE OF DEATH Enter only one cause per line for (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (aa) (ab) (ac) (ad) (ae) (af) (ag) (ah) (ai) (aj) (ak) (al) (am) (an) (ao) (ap) (aq) (ar) (as) (at) (au) (av) (aw) (ax) (ay) (az) (ba) (bb) (bc) (bd) (be) (bf) (bg) (bh) (bi) (bj) (bk) (bl) (bm) (bn) (bo) (bp) (bq) (br) (bs) (bt) (bu) (bv) (bw) (bx) (by) (bz) (ca) (cb) (cc) (cd) (ce) (cf) (cg) (ch) (ci) (cj) (ck) (cl) (cm) (cn) (co) (cp) (cq) (cr) (cs) (ct) (cu) (cv) (cw) (cx) (cy) (cz) (da) (db) (dc) (dd) (de) (df) (dg) (dh) (di) (dj) (dk) (dl) (dm) (dn) (do) (dp) (dq) (dr) (ds) (dt) (du) (dv) (dw) (dx) (dy) (dz) (ea) (eb) (ec) (ed) (ee) (ef) (eg) (eh) (ei) (ej) (ek) (el) (em) (en) (eo) (ep) (eq) (er) (es) (et) (eu) (ev) (ew) (ex) (ey) (ez) (fa) (fb) (fc) (fd) (fe) (ff) (fg) (fh) (fi) (fj) (fk) (fl) (fm) (fn) (fo) (fp) (fq) (fr) (fs) (ft) (fu) (fv) (fw) (fx) (fy) (fz) (ga) (gb) (gc) (gd) (ge) (gf) (gg) (gh) (gi) (gj) (gk) (gl) (gm) (gn) (go) (gp) (gq) (gr) (gs) (gt) (gu) (gv) (gw) (gx) (gy) (gz) (ha) (hb) (hc) (hd) (he) (hf) (hg) (hh) (hi) (hj) (hk) (hl) (hm) (hn) (ho) (hp) (hq) (hr) (hs) (ht) (hu) (hv) (hw) (hx) (hy) (hz) (ia) (ib) (ic) (id) (ie) (if) (ig) (ih) (ii) (ij) (ik) (il) (im) (in) (io) (ip) (iq) (ir) (is) (it) (iu) (iv) (iw) (ix) (iy) (iz) (ja) (jb) (jc) (jd) (je) (jf) (jg) (jh) (ji) (jj) (jk) (jl) (jm) (jn) (jo) (jp) (jq) (jr) (js) (jt) (ju) (jv) (jw) (jx) (jy) (jz) (ka) (kb) (kc) (kd) (ke) (kf) (kg) (kh) (ki) (kj) (kk) (kl) (km) (kn) (ko) (kp) (kq) (kr) (ks) (kt) (ku) (kv) (kw) (kx) (ky) (kz) (la) (lb) (lc) (ld) (le) (lf) (lg) (lh) (li) (lj) (lk) (ll) (lm) (ln) (lo) (lp) (lq) (lr) (ls) (lt) (lu) (lv) (lw) (lx) (ly) (lz) (ma) (mb) (mc) (md) (me) (mf) (mg) (mh) (mi) (mj) (mk) (ml) (mm) (mn) (mo) (mp) (mq) (mr) (ms) (mt) (mu) (mv) (mw) (mx) (my) (mz) (na) (nb) (nc) (nd) (ne) (nf) (ng) (nh) (ni) (nj) (nk) (nl) (nm) (nn) (no) (np) (nq) (nr) (ns) (nt) (nu) (nv) (nw) (nx) (ny) (nz) (oa) (ob) (oc) (od) (oe) (of) (og) (oh) (oi) (oj) (ok) (ol) (om) (on) (oo) (op) (oq) (or) (os) (ot) (ou) (ov) (ow) (ox) (oy) (oz) (pa) (pb) (pc) (pd) (pe) (pf) (pg) (ph) (pi) (pj) (pk) (pl) (pm) (pn) (po) (pp) (pq) (pr) (ps) (pt) (pu) (pv) (pw) (px) (py) (pz) (qa) (qb) (qc) (qd) (qe) (qf) (qg) (qh) (qi) (qj) (qk) (ql) (qm) (qn) (qo) (qp) (qq) (qr) (qs) (qt) (qu) (qv) (qw) (qx) (qy) (qz) (ra) (rb) (rc) (rd) (re) (rf) (rg) (rh) (ri) (rj) (rk) (rl) (rm) (rn) (ro) (rp) (rq) (rr) (rs) (rt) (ru) (rv) (rw) (rx) (ry) (rz) (sa) (sb) (sc) (sd) (se) (sf) (sg) (sh) (si) (sj) (sk) (sl) (sm) (sn) (so) (sp) (sq) (sr) (ss) (st) (su) (sv) (sw) (sx) (sy) (sz) (ta) (tb) (tc) (td) (te) (tf) (tg) (th) (ti) (tj) (tk) (tl) (tm) (tn) (to) (tp) (tq) (tr) (ts) (tt) (tu) (tv) (tw) (tx) (ty) (tz) (ua) (ub) (uc) (ud) (ue) (uf) (ug) (uh) (ui) (uj) (uk) (ul) (um) (un) (uo) (up) (uq) (ur) (us) (ut) (uu) (uv) (uw) (ux) (uy) (uz) (va) (vb) (vc) (vd) (ve) (vf) (vg) (vh) (vi) (vj) (vk) (vl) (vm) (vn) (vo) (vp) (vq) (vr) (vs) (vt) (vu) (vv) (vw) (vx) (vy) (vz) (wa) (wb) (wc) (wd) (we) (wf) (wg) (wh) (wi) (wj) (wk) (wl) (wm) (wn) (wo) (wp) (wq) (wr) (ws) (wt) (wu) (wv) (ww) (wx) (wy) (wz) (xa) (xb) (xc) (xd) (xe) (xf) (xg) (xh) (xi) (xj) (xk) (xl) (xm) (xn) (xo) (xp) (xq) (xr) (xs) (xt) (xu) (xv) (xw) (xx) (xy) (xz) (ya) (yb) (yc) (yd) (ye) (yf) (yg) (yh) (yi) (yj) (yk) (yl) (ym) (yn) (yo) (yp) (yq) (yr) (ys) (yt) (yu) (yv) (yw) (yx) (yy) (yz) (za) (zb) (zc) (zd) (ze) (zf) (zg) (zh) (zi) (zj) (zk) (zl) (zm) (zn) (zo) (zp) (zq) (zr) (zs) (zt) (zu) (zv) (zw) (zx) (zy) (zz)													

MEDICAL CERTIFICATION

18 CAUSE OF DEATH Enter only one cause per line for (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (aa) (ab) (ac) (ad) (ae) (af) (ag) (ah) (ai) (aj) (ak) (al) (am) (an) (ao) (ap) (aq) (ar) (as) (at) (au) (av) (aw) (ax) (ay) (az) (ba) (bb) (bc) (bd) (be) (bf) (bg) (bh) (bi) (bj) (bk) (bl) (bm) (bn) (bo) (bp) (bq) (br) (bs) (bt) (bu) (bv) (bw) (bx) (by) (bz) (ca) (cb) (cc) (cd) (ce) (cf) (cg) (ch) (ci) (cj) (ck) (cl) (cm) (cn) (co) (cp) (cq) (cr) (cs) (ct) (cu) (cv) (cw) (cx) (cy) (cz) (da) (db) (dc) (dd) (de) (df) (dg) (dh) (di) (dj) (dk) (dl) (dm) (dn) (do) (dp) (dq) (dr) (ds) (dt) (du) (dv) (dw) (dx) (dy) (dz) (ea) (eb) (ec) (ed) (ee) (ef) (eg) (eh) (ei) (ej) (ek) (el) (em) (en) (eo) (ep) (eq) (er) (es) (et) (eu) (ev) (ew) (ex) (ey) (ez) (fa) (fb) (fc) (fd) (fe) (ff) (fg) (fh) (fi) (fj) (fk) (fl) (fm) (fn) (fo) (fp) (fq) (fr) (fs) (ft) (fu) (fv) (fw) (fx) (fy) (fz) (ga) (gb) (gc) (gd) (ge) (gf) (gg) (gh) (gi) (gj) (gk) (gl) (gm) (gn) (go) (gp) (gq) (gr) (gs) (gt) (gu) (gv) (gw) (gx) (gy) (gz) (ha) (hb) (hc) (hd) (he) (hf) (hg) (hh) (hi) (hj) (hk) (hl) (hm) (hn) (ho) (hp) (hq) (hr) (hs) (ht) (hu) (hv) (hw) (hx) (hy) (hz) (ia) (ib) (ic) (id) (ie) (if) (ig) (ih) (ii) (ij) (ik) (il) (im) (in) (io) (ip) (iq) (ir) (is) (it) (iu) (iv) (iw) (ix) (iy) (iz) (ja) (jb) (jc) (jd) (je) (jf) (jg) (jh) (ji) (jj) (jk) (jl) (jm) (jn) (jo) (jp) (jq) (jr) (js) (jt) (ju) (jv) (jw) (jx) (jy) (jz) (ka) (kb) (kc) (kd) (ke) (kf) (kg) (kh) (ki) (kj) (kk) (kl) (km) (kn) (ko) (kp) (kq) (kr) (ks) (kt) (ku) (kv) (kw) (kx) (ky) (kz) (la) (lb) (lc) (ld) (le) (lf) (lg) (lh) (li) (lj) (lk) (ll) (lm) (ln) (lo) (lp) (lq) (lr) (ls) (lt) (lu) (lv) (lw) (lx) (ly) (lz) (ma) (mb) (mc) (md) (me) (mf) (mg) (mh) (mi) (mj) (mk) (ml) (mm) (mn) (mo) (mp) (mq) (mr) (ms) (mt) (mu) (mv) (mw) (mx) (my) (mz) (na) (nb) (nc) (nd) (ne) (nf) (ng) (nh) (ni) (nj) (nk) (nl) (nm) (nn) (no) (np) (nq) (nr) (ns) (nt) (nu) (nv) (nw) (nx) (ny) (nz) (oa) (ob) (oc) (od) (oe) (of) (og) (oh) (oi) (oj) (ok) (ol) (om) (on) (oo) (op) (oq) (or) (os) (ot) (ou) (ov) (ow) (ox) (oy) (oz) (pa) (pb) (pc) (pd) (pe) (pf) (pg) (ph) (pi) (pj) (pk) (pl) (pm) (pn) (po) (pp) (pq) (pr) (ps) (pt) (pu) (pv) (pw) (px) (py) (pz) (qa) (qb) (qc) (qd) (qe) (qf) (qg) (qh) (qi) (qj) (qk) (ql) (qm) (qn) (qo) (qp) (qq) (qr) (qs) (qt) (qu) (qv) (qw) (qx) (qy) (qz) (ra) (rb) (rc) (rd) (re) (rf) (rg) (rh) (ri) (rj) (rk) (rl) (rm) (rn) (ro) (rp) (rq) (rr) (rs) (rt) (ru) (rv) (rw) (rx) (ry) (rz) (sa) (sb) (sc) (sd) (se) (sf) (sg) (sh) (si) (sj) (sk) (sl) (sm) (sn) (so) (sp) (sq) (sr) (ss) (st) (su) (sv) (sw) (sx) (sy) (sz) (ta) (tb) (tc) (td) (te) (tf) (tg) (th) (ti) (tj) (tk) (tl) (tm) (tn) (to) (tp) (tq) (tr) (ts) (tt) (tu) (tv) (tw) (tx) (ty) (tz) (ua) (ub) (uc) (ud) (ue) (uf) (ug) (uh) (ui) (uj) (uk) (ul) (um) (un) (uo) (up) (uq) (ur) (us) (ut) (uu) (uv) (uw) (ux) (uy) (uz) (va) (vb) (vc) (vd) (ve) (vf) (vg) (vh) (vi) (vj) (vk) (vl) (vm) (vn) (vo) (vp) (vq) (vr) (vs) (vt) (vu) (vv) (vw) (vx) (vy) (vz) (wa) (wb) (wc) (wd) (we) (wf) (wg) (wh) (wi) (wj) (wk) (wl) (wm) (wn) (wo) (wp) (wq) (wr) (ws) (wt) (wu) (wv) (ww) (wx) (wy) (wz) (xa) (xb) (xc) (xd) (xe) (xf) (xg) (xh) (xi) (xj) (xk) (xl) (xm) (xn) (xo) (xp) (xq) (xr) (xs) (xt) (xu) (xv) (xw) (xx) (xy) (xz) (ya) (yb) (yc) (yd) (ye) (yf) (yg) (yh) (yi) (yj) (yk) (yl) (ym) (yn) (yo) (yp) (yq) (yr) (ys) (yt) (yu) (yv) (yw) (yx) (yy) (yz) (za) (zb) (zc) (zd) (ze) (zf) (zg) (zh) (zi) (zj) (zk) (zl) (zm) (zn) (zo) (zp) (zq) (zr) (zs) (zt) (zu) (zv) (zw) (zx) (zy) (zz)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from September 81 to November 82 , that (I) (we) lost saw the deceased alive on November 26 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Daniel I. Welliver MD		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11-26-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANIEL I. WELLIVER MD		22e. ADDRESS 210 WASHINGTON HEIGHTS WESTMINSTER MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-2-82		23c. NAME OF CEMETERY OR CREMATORY AMHERST		23d. LOCATION CITY OR TOWN COUNTY STATE AMHERST HAMPSHIRE MASS.	
24 FUNERAL DIRECTOR NAME Robert Kyle Butts Jr. ADDRESS Westminster, Md				25a. DATE REC'D. BY REGISTRAR DEC 2 1982 REGISTRAR'S SIGNATURE James A. Cairns			



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 2 9 2 1 9			
1. FOR STATE REGISTRAR				20. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ella A. CRAMER				20. DATE OF DEATH MONTH DAY YEAR Nov. - 4 - 92			
3. SEX Female				2b. HOUR 1:30 A.M.			
4. RACE White				5. DATE OF BIRTH MONTH DAY YEAR 4 - 20 - 1892			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.				6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.			
7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
10. CITY OR TOWN OF DEATH Westminster				9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Westminster Nazareth Conv. Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Virginia 13b. COUNTY Prince Georges				12b. KIND OF BUSINESS OR INDUSTRY			
13c. CITY OR TOWN Hemlock				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Thomas E. Cogan				13e. STREET ADDRESS 9407 Rebnul Rd.			
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Julia Ralys				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 212-52-1556				17. INFORMANT ADDRESS Ann C. Kurtz, 4220 Backwoods Rd. Westminister, Md. 21157			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Terminal pneumonia. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD. DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS 6 YEARS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7/28 1978, to 11-4 1982, that I (we) lost saw the deceased alive on 11/4 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Daniel J. Welliver MD				DEGREE MD		22c. DATE SIGNED 11-4-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANIEL J. WELLIVER				22e. ADDRESS 218 WASHINGTON HEIGHTS WESTMINSTER MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 6, 1982		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Montgomery Md.	
24. FUNERAL DIRECTOR NAME Olin L. Molesworth, P.A., Damascus, Md.				25. DATE OF DEATH NOV 8 1982			

Minneapolis

Office

Mr. J. H. ...
... ..

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM-3, RETAIN PAGE 5 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2. 29220	
1. DECEASED NAME (TYPE OR PRINT) George H. Danner		2a. DATE KNOWN OF DEATH ESTIMATED 11/16/82	
3. SEX Male	4. RACE White	5. DATE OF BIRTH Aug. 19, 11	6. AGE (IN YEARS) 71 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Carroll Co. Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD 11/16/82
10. CITY OR TOWN OF DEATH Hampstead	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3920 Shiloh Ave.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Stone Mason	12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.	13b. COUNTY Carroll	13c. CITY OR TOWN Hampstead	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Herbert W. Danner		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith Brummel	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes WW 2		16b. SOCIAL SECURITY NO. 220-07-2891	
17. INFORMANT Pauline Danner		ADDRESS Hampstead, Md. 21074	
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic Cardiovascular Disease</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Richard A. Jones</i>		TITLE (SPECIFY) M.D. <i>Deputy</i> MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) Richard A. Jones		ADDRESS Westminster, Md. 21157	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Nov. 18, 82	23c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial	23d. LOCATION CITY OR TOWN COUNTY STATE Finksburg, Carroll Md.
24. FUNERAL DIRECTOR NAME Eline Funeral Home		25a. DATE REC'D. BY REGISTRAR NOV 24 1982	
ADDRESS Hampstead, Md. 21074		25b. REGISTRAR'S SIGNATURE <i>John J. Coniff</i>	

THE NEW YORK
COTTON EXCHANGE
INCORPORATED

MEMORANDUM

NOV 2 1918

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 9 2 2 1 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <u>Ethel Irene Dell</u>				2a. DATE OF DEATH MONTH DAY YEAR <u>11/28/82</u>				2b. HOUR <u>9¹⁵</u> A M
3. SEX <u>Female</u>		4. RACE <u>Cauc</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>May 29 1901</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>81</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Cannell Conn. Md.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Cannell</u> MD.		
10. CITY OR TOWN OF DEATH <u>Manchester</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Long View Nsg. Home</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE <u>Md.</u>		13b. COUNTY <u>Cannell</u>		13c. CITY OR TOWN <u>Westminster</u>		13e. STREET ADDRESS <u>518 Willow Ave.</u> 21157		
14. FATHER'S NAME FIRST MIDDLE LAST <u>Marshall Knight</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Amanda Taylor</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>217-12-1281</u>		17. INFORMANT ADDRESS <u>Betty M. Mann. SCAR 413</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <u>4292</u> IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiac Vascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>2 yrs</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>6-16</u> 19 <u>82</u> , to <u>11/27</u> 19 <u>82</u> , that I (we) last saw the deceased alive on <u>11/12</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>W. H. Foard MD</u>				DEGREE				22c. DATE SIGNED <u>11/28/82</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>W. H. Foard MD.</u>				22e. ADDRESS <u>3223 Main St Manchester, Md 21102</u>				
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <u>Burial</u>		23b. DATE <u>12-1-1982</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Nesley Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Hampstead Carroll Md.</u>		
24. FUNERAL DIRECTOR NAME <u>Thomas Fletcher</u> ADDRESS <u>254 E. Main St Westminster Md. 21157</u>				25a. DATE REC'D. BY REGISTRAR <u>DEC 2 1982</u>				
				25b. REGISTRAR'S SIGNATURE <u>John J. Cannon</u>				

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[Faint, mostly illegible handwriting on lined paper]

LIBRARY

WINTER



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

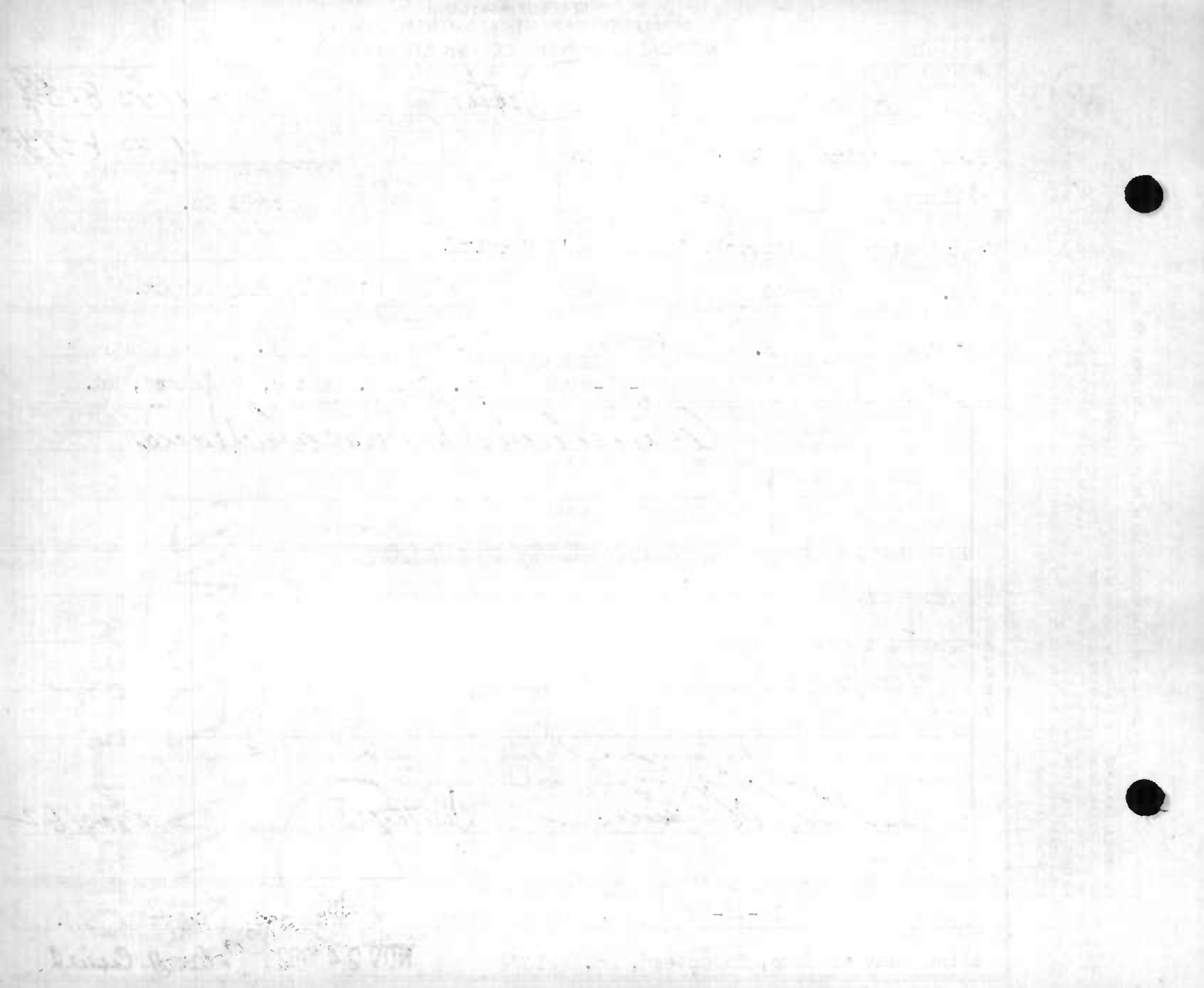
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Ruth V. Dexter</i>			2a. DATE KNOWN OF DEATH MONTH DAY YEAR <i>11 22 1982</i>		
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>12 11 21 60 YRS.</i>	6. AGE (IN YEARS) LAST BIRTHDAY <i>60 YRS.</i>	7. IF UNDER 1 YR. MONTHS DAYS HOURS MINS	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>11 22 1982</i>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Illinois</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <i>Westminster</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Carroll County Gen'l Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Hwf</i>	
13a. STATE <i>Md.</i>		13b. COUNTY <i>Carroll</i>	13c. CITY OR TOWN <i>Hampstead</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>George H. Varney</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Elsie E. Ekstrand</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>577-24-9398</i>		17. INFORMANT ADDRESS <i>Mr. Alan D. Dexter, Hampstead, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Atherosclerotic Cardiovascular Disease</i> 4292 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>[Signature]</i>		TITLE SPECIFY <i>[Signature]</i>		DATE SIGNED <i>22 Nov 82</i>	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>11-26-82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Hampstead Cemetery</i>	
24. FUNERAL DIRECTOR NAME <i>Eline Funeral Home, Hampstead, Md. 21074</i>		25a. DATE REC'D. BY REGISTRAR <i>NOV 24 1982</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
23d. LOCATION CITY OR TOWN <i>Hampstead</i>		COUNTY <i>Carroll</i>		STATE <i>Md.</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

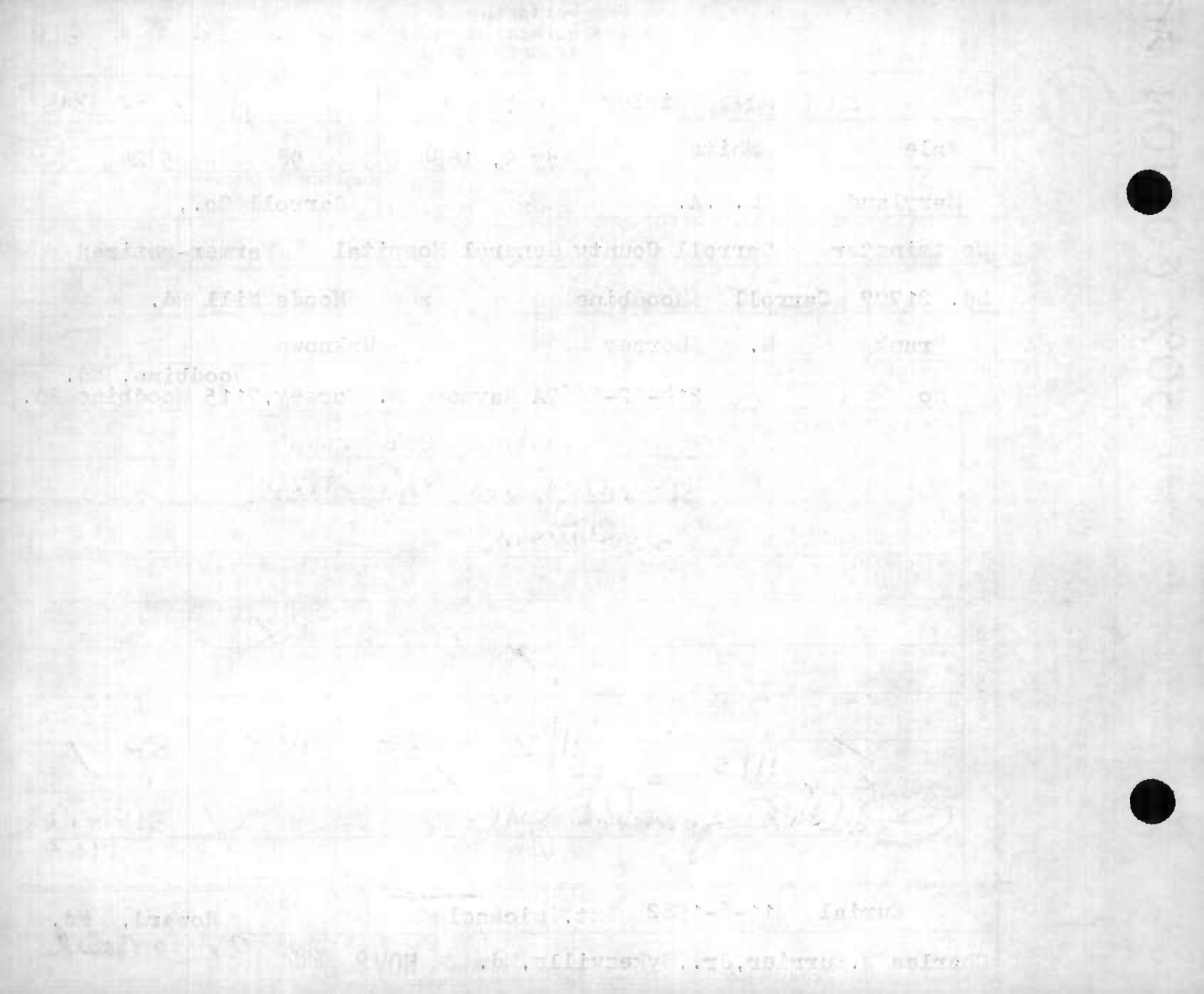
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 9 2 2 3			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
EDWARD Wigley DORSEY								11		3	82	1345	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White		May 9, 1884		98		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		U.S.A.				Carroll Co.,						MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Westminster		Carroll County General Hospital								Farmer-		retired	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Hoods Mill Rd.					
Md. 21797		Carroll		Woodbine									
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST			
Frank		W.		Dorsey		Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No				214-32-26694		Raymond N. Dorsey,		7115 Woodbine Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>gram negative septicemia</u> <u>6000</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>urinary tract infection</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>septicemia</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <u>11/2</u> 19 <u>82</u> , to <u>11/3</u> 19 <u>82</u> , that (1) (we) lost saw the deceased alive on <u>11/3</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) (did) (did not) view the body after death.				DEGREE				22c. DATE SIGNED					
22b. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS				3 November 1982					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial				11-6-1982		St. Michaels		Howard, Md.					
24. FUNERAL DIRECTOR NAME								25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Charles W. Burrier, Jr., Yorkesville, Md.								NOV 8 1982		[Signature]			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 9 2 2 4			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST Lucille		MIDDLE Lota		LAST Duggan		2a. DATE OF DEATH		MONTH 11	DAY 12	YEAR 82	2b. HOUR 12:25 PM
3. SEX Female		4. RACE White		5. DATE OF BIRTH		MONTH 10		DAY 21		YEAR 02		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mississippi		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.							
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Springfield Hospital Center											
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY -											
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Md.				13b. COUNTY Frederick		13c. CITY OR TOWN Frederick		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1614 Shookstown Road, 21701			
14. FATHER'S NAME FIRST Allen				MIDDLE P.		LAST Waters		15. MOTHER'S MAIDEN NAME FIRST Lela		MIDDLE Sargent		LAST Sargent	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		410-34-6166		17. INFORMANT Mrs. Ralph Merchant, Frederick, Md. 21701							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 4409 IMMEDIATE CAUSE (a) CARDIAC ARREST. DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO-SCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: PNEUMONIA													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 11/12 1982, to 11/12 1982, that (I) (we) last saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE FORTUONDO J.		DEGREE						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS SPRINGFIELD STATE HOSP.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov 16, 1982		23c. NAME OF CEMETERY OR CREMATORY Resthaven Memorial Gardens, Frederick, Md.				23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR Smith, Keeney and Basford Funeral Home 106 East Church St., Frederick, Md. 21701		25a. DATE REC'D BY REGISTRAR NOV 16 1982											

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 2 9 2 2 5					
1 - FOR STATE REGISTRAR										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)					FIRST MIDDLE LAST					2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
John					K. Elseroad					11 4 82				2142M	
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS					
Male		White		MONTH DAY YEAR 7 6 1915		67 YRS.		MONTHS DAYS		HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
Maryland		USA				Carroll County MD.									
10 CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Westminster				Carroll County Gen'l Hospital				Driver				Gas Company			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Md.				Carroll		Hampstead		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1634 N. Main Street					
14 FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
David Elseroad					Jennie Leister										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS					
yes WW2					275-18-3986					Mrs. Hazel Elseroad, Hampstead, Md. 21074					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <u>CARDIAC ARRHYTHMIA</u>												MINUTES			
4100 DUE TO, OR AS A CONSEQUENCE OF															
(b) <u>MYOCARDIAL ISCHEMIA - POSS INFARCTION</u>															
DUE TO, OR AS A CONSEQUENCE OF															
(c) <u>ATHEROSCLEROTIC CORONARY HEART DISEASE YEARS</u>															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>7</u> 19 <u>81</u> to <u>13</u> 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>11/4</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>James H. Jones, Jr. MD</u>								DEGREE		22c. DATE SIGNED					
								ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		11/4/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)								22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial				11-8-82		Leister's Cemetery				Westminster Carroll Md.					
24 FUNERAL DIRECTOR NAME								ADDRESS		25a. DATE REC'D. BY REGISTRAR					
Eline Funeral Home, Hampstead, Md. 21074										NOV 8 1982 <u>John J. Leister</u>					

NOV 8 1952

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 2 2 6

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) LEVI			FIRST Leonard Flohr			MIDDLE Flohr			LAST Flohr			2a. DATE OF DEATH MONTH DAY YEAR 11 26 82			2b. HOUR 3:02 PM		
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR Feb. 16, 1902			6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL County MD.								
10. CITY OR TOWN OF DEATH Westminster			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL County Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARMER			12b. KIND OF BUSINESS OR INDUSTRY AGRI.					
13a. STATE Md.			13b. COUNTY CARROLL			13c. CITY OR TOWN Westminster			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 109 Bertie Ave					
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin S. Flohr						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CARRIE Fowble											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 217 36 4429			17. INFORMANT ADDRESS Helen Wilson - Sykesville, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTIC SHOCK 5316 DUE TO, OR AS A CONSEQUENCE OF (b) PERITONITIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) PERFORATED GASTRIC ULCER												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) ACUTE RESPIRATORY FAILURE																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from 11-24 , 19 82 , to 11-26 , 19 82 , that (I) (we) lost saw the deceased alive on 11-26 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE MANUEL J. Sevilla						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 11-26-82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MANUEL J. Sevilla						22e. ADDRESS 414C Malcolm Dr WESTMINSTER											
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial			23b. DATE 11-30-82			23c. NAME OF CEMETERY OR CREMATORY Springfield Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Carroll Md.								
24. FUNERAL DIRECTOR NAME Harry W. Haight						ADDRESS Sykesville, Md.						DATE RECEIVED BY REGISTRAR NOV 29 1982		REGISTRAR'S SIGNATURE Jan L. Conner			

MEDICAL CERTIFICATION

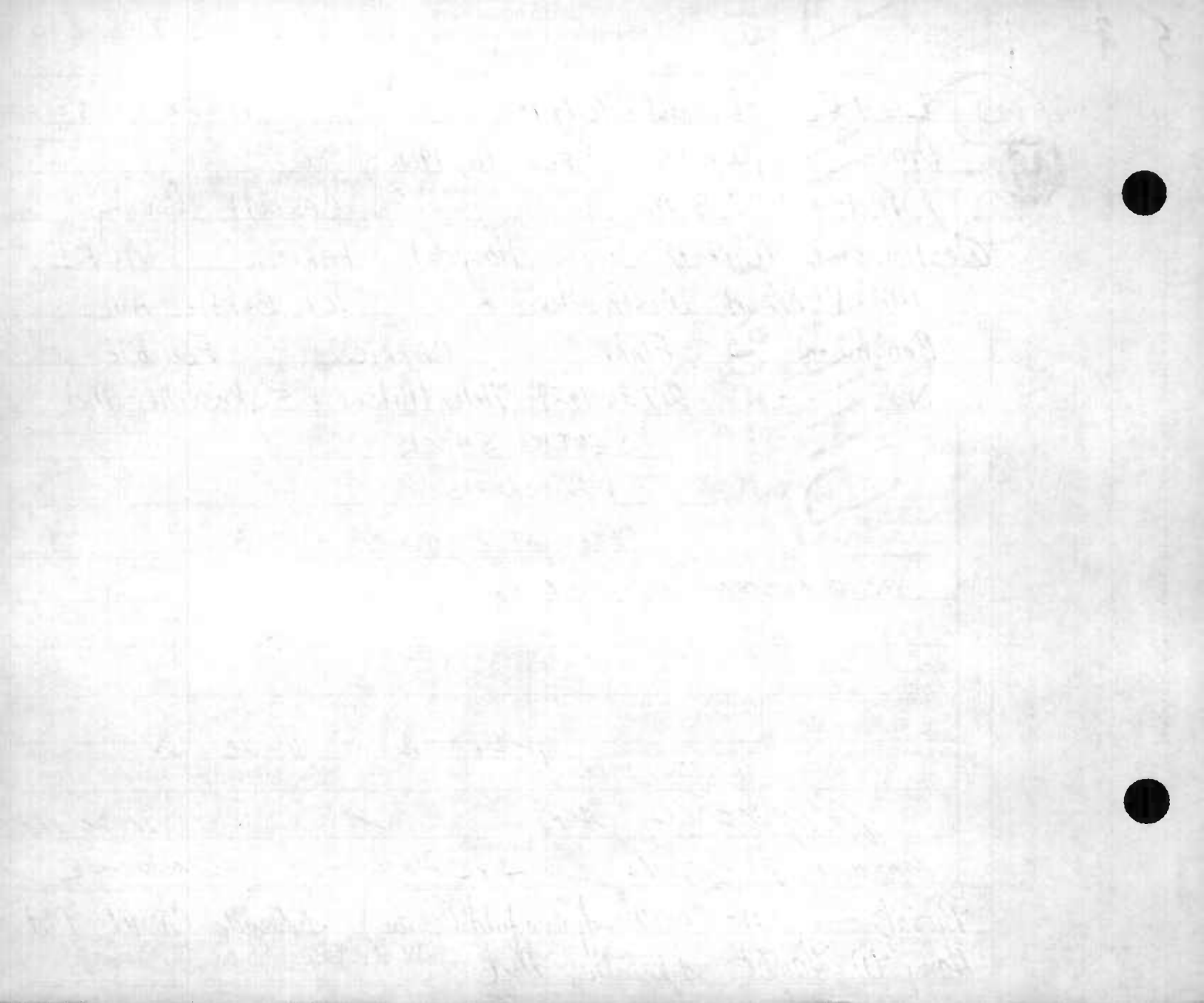
29

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

BP





STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 2 2 7

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
		HARRY Edwin FOGLE		11		2		82		0547		A	
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White		Oct. 15 1912		70		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Carroll County		U.S.A.				Carroll						MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Westminster		Carroll County General Hospital		Track driver		S. H. Tevis							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland		Carroll		Westminster		YES <input type="checkbox"/> NO <input type="checkbox"/>		37 John Street				21157	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Henry Thomas Fogle		Mary Susan Winter											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS									
No		213-10-9237		Minnie Grace Fogle 37 John St.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>anoxic encephalopathy</i> <i>4140</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>cardiac arrest</i> (c) <i>atherosclerotic heart disease</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FATAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		<i>renal failure, respiratory failure</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (this hospital) attended the deceased from <i>8/25</i> 19 <i>82</i> to <i>10/2</i> 19 <i>82</i> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <i>11/2</i> 19 <i>82</i> and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did) <input checked="" type="checkbox"/> did not view the body after death													
22b. SIGNATURE <i>Paul W. Espenschade Jr.</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>2 November 1982</i>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Paul W. Espenschade Jr. MD</i>		22e. ADDRESS <i>218 Washington Heights, Westminster, Md.</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial		11-5-82		Krider's Cemetery		Westminster Carroll Md.							
24. FUNERAL DIRECTOR NAME		25a. ADDRESS		25b. BY REGISTRATION		25c. REGISTRAR'S SIGNATURE							
<i>Ed Fletcher</i>		254 East Main Westminster, Md.		<i>11/8 1982</i>		<i>[Signature]</i>							

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MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

NOTICE

1910

Notice of the Board of Directors

of the

of the Board of Directors

of the Board of Directors

of the Board of Directors

of the Board of Directors

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD WRITE "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1, AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

10

1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Margaret Ann Fryrear			2b. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <input checked="" type="checkbox"/> 11 20 19 82			2c. HOUR 1445	
1. SEX F.	4. RACE W.	5. DATE OF BIRTH MONTH 05 DAY 20 YEAR 25	6. AGE (IN YEARS) LAST BIRTHDAY 57 YRS.	IF UNDER 1 YR. MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN 0	2d. DATE PRONOUNCED DEAD MONTH 11 DAY 20 YEAR 19 82	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll Co.	
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Co Gen'l Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE MD		13b. COUNTY Howard		13c. CITY OR TOWN Savage		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST Sigmond MIDDLE Spatz LAST Spatz		15. MOTHER'S MAIDEN NAME FIRST Susanna MIDDLE Chwerk LAST Chwerk		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 405380688	
17. INFORMANT Chart Albert Fryrear		ADDRESS Savage, Md		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4029 Cardiac arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 75 Min	
DUE TO, OR AS A CONSEQUENCE OF HASCVD		DUE TO, OR AS A CONSEQUENCE OF 5 yrs		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). 4029			
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? —		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS: UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. 19 P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) —			
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, PARK, ETC.) —		21f. LOCATION STREET — CITY OR TOWN — COUNTY — STATE —			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		TITLE (SPECIFY) Asst Deputy		DATE SIGNED 11-20-82	
ACTUAL SIGNATURE Alva S. Baker		M.D. Alva S. Baker		MEDICAL EXAMINER 218 Washington Heights Md Ctr		ADDRESS MD 21157	
EXAMINER'S NAME (TYPE OR PRINT) Alva S. Baker		ADDRESS 218 Washington Heights Md Ctr		DATE REC'D. BY REGISTRAR NOV 23 1982		REGISTRAR'S SIGNATURE James J. Conish	
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial		23b. DATE 11-24-82		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cemetery		23d. LOCATION CITY OR TOWN Arlington COUNTY Va. STATE Va.	
24. FUNERAL DIRECTOR NAME Harry W. Haight ADDRESS Sykesville, Md.		25. DATE REC'D. BY REGISTRAR NOV 23 1982		REGISTRAR'S SIGNATURE James J. Conish			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LUCY CATHERINE GAVER					2a. DATE OF DEATH MONTH DAY YEAR Mar 27, 1982			2b. HOUR 1545M	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR JUNE 17 1915		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.			
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL CO				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MACHINE OPERATOR		12b. KIND OF BUSINESS OR INDUSTRY KNIT CLOTHING	
13a. STATE MARYLAND					13b. COUNTY CARROLL		13c. CITY OR TOWN WESTMINSTER		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST MILTON V MILLER					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY ELGIN FRITZ				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 220-07-9471		17. INFORMANT ADDRESS P. EDWARD GAVER WESTMINSTER MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 5714 IMMEDIATE CAUSE (a) Hepatic failure DUE TO, OR AS A CONSEQUENCE OF (b) Chronic active Hepatitis DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Mar 11, 1982 to Mar 27, 1982 , that (I) (we) lost the deceased on Mar 27, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John S. Harshey, M.D.					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11/27/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN S. HARSHEY, MD					22e. ADDRESS 8 Archer St. Westminster, Md. 21157				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC 1- 1982		23c. NAME OF CEMETERY OR CREMATORY HAUGHS		23d. LOCATION CITY OR TOWN COUNTY STATE LADIESBURG FREDERICK MD			
24. FUNERAL DIRECTOR NAME D S Hartzler					25a. DATE REC'D. BY REGISTRAR NOV 30 1982				
ADDRESS Union Bridge, Md					REGISTRAR'S SIGNATURE John J. Conner				

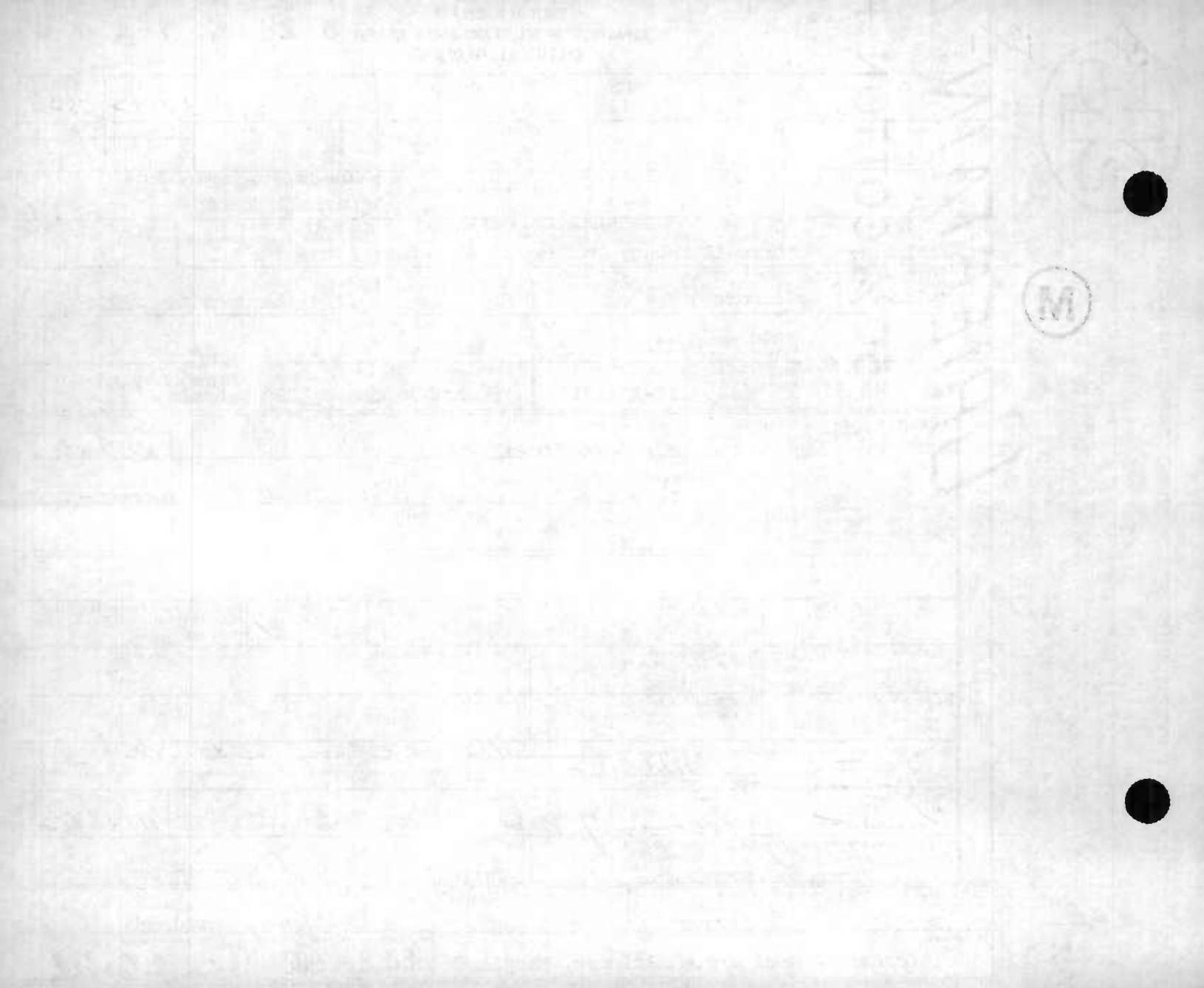
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) May W Hanson					2a. DATE OF DEATH MONTH DAY YEAR 11 30 82				
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb 2, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7b. HOUR 0820 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.			
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County Gen Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1704 Aberdeen Rd 21234	
14. FATHER'S NAME FIRST MIDDLE LAST Robert Wallis					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Wacker				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-22-8711		17. INFORMANT ADDRESS Leonard M Hanson Pasadena, Md 328 Oakdale Rd					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1579 IMMEDIATE CAUSE (a) CARCINOMATOSIS DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF PANCREAS DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE, LAST.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH WEEKS MONTHS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 11/25, 1982, to 11/30, 1982, that (I) (we) last saw the deceased alive on 11/30, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Vincent Fisco M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 11/30/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Vincent Fisco M.D.				22e. ADDRESS Carroll Co Gen Hosp Westminster, Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/3/82		23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME Leonard J Ruck Inc. Baltimore, Maryland				25a. DATE REC'D. BY REGISTRAR DEC 2 - 1982		25b. REGISTRAR'S SIGNATURE John J. Connel			



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 2 3 1

1 - FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Roland E. Hewell</i>			2a DATE OF DEATH MONTH DAY YEAR <i>11/10/82</i>			7b HOUR <i>6 A.M.</i>			
3 SEX <i>Male</i>		4 RACE <i>White</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>Sept. 4 1910</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>72</i>		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>D.C.</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>CARROLL</i>			
10 CITY OR TOWN OF DEATH <i>Westminster</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>3541 Halter Road</i>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>FARMER</i>		12b KIND OF BUSINESS OR INDUSTRY <i>FARMING</i>	
13a STATE <i>Maryland</i>		13b COUNTY <i>Carroll</i>		13c CITY OR TOWN <i>Westminster</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS <i>3541 HALTER ROAD</i>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>UNKNOWN</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>UNKNOWN</i>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>168-14-2669</i>		17 INFORMANT ADDRESS <i>Helen Jewell 3541 Halter Road 21157 Westminster, MD</i>					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIOPULMONARY ARREST</i> <i>1629</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>LUNG CANCER</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>—</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 MIN</i> <i>1 YEAR</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>None</i>									
19a DATE OF OPERATION <i>—</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <i>11/6</i> 19 <i>82</i> to <i>present</i> 19 <i>82</i> . If (or if we) lost saw the deceased alive on above (if we did not) view the body after death.									
22b. SIGNATURE <i>John Lehman</i>		PER DEGREE <i>PH.D. LUTHERICUM, TAYMERTOWN, MD.</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED <i>11/10/82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>JOHN LEHMAN</i>		22e. ADDRESS <i>104 N. MAIN ST. UNION BRIDGE, MD.</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>Nov. 13 1982</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Mary's Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Silver Run Carroll MD</i>			
24. FUNERAL DIRECTOR NAME <i>Rufus L. L. L.</i>		ADDRESS <i>3110 Maple Ave 17340</i>		25a. DATE REC'D. BY REGISTRAR <i>NOV 17 1982</i>		25b. REGISTRAR'S SIGNATURE <i>John J. L. L.</i>			

MEDICAL CERTIFICATION

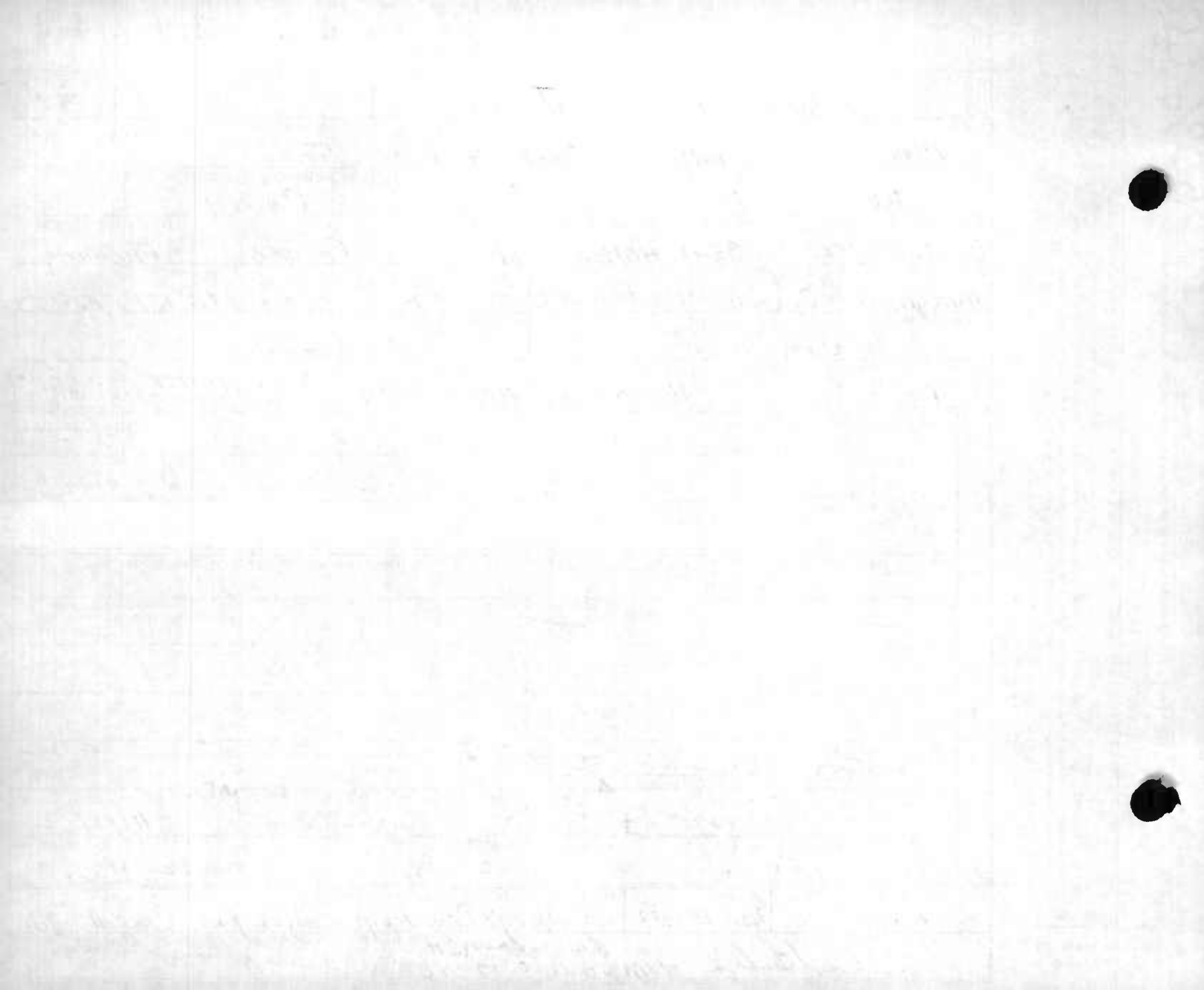
29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post-mortem examinations should be made as soon as possible after death. The low requires that the death certificate be executed within 24 hours after death. Post-mortem examinations should be made as soon as possible after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 2 3 2

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JAMES H. HUSTIS JR.			2a. DATE OF DEATH MONTH DAY YEAR NOV 5 1982			2b. HOUR 10:30 P.M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 2 13 1893		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MT. VERNON N.Y.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.	
10. CITY OR TOWN OF DEATH SYKESVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FAIRHAVEN				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TERMINAL MANG.	
12b. KIND OF BUSINESS OR INDUSTRY RAILROAD							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE MD.		13b. COUNTY CARROLL		13c. CITY OR TOWN SYKESVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 7200 THIRD STREET							
14. FATHER'S NAME FIRST MIDDLE LAST JAMES H. HUSTIS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EVELYN STUDLEY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) XXX YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW1		17. INFORMANT ADDRESS SELF			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARRHYTHMIA 4292 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/2 , 19 80 , to 11/5 , 19 82 , that (I) (we) last saw the deceased alive on 11/5 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Ellis Mez MD		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 11/6/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ellis Mez, MD		22e. ADDRESS 1425 Liberty Rd. Eldersburg, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 11-10-82		23c. NAME OF CEMETERY OR CREMATORY COLD SPRING		23d. LOCATION CITY OR TOWN COUNTY STATE COLD SPRING PUTNAM N.Y.	
24. FUNERAL DIRECTOR NAME ADDRESS PRITTS FUNERAL HOME WESTMINSTER, MD.				25a. DATE REC'D. BY REGISTRAR NOV 12 1982			

MEDICAL CERTIFICATION

29

BP

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 9 2 3 3			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) ADDIE		FIRST ADDIE MIDDLE E. LAST LASSEN		2a. DATE OF DEATH MONTH NOV. DAY 17 YEAR 1982		2b. HOUR 7 MIN. 40	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH Jan. DAY 10 YEAR 1889		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL County MD.	
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WESTMINSTER NURS. & CONV. CTR.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Parkville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST John MIDDLE LAST Morhiser		15. MOTHER'S MAIDEN NAME FIRST Addie MIDDLE LAST Ball		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 220-44-2199	
17. INFORMANT Ocean View, Delaware		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Atherosclerotic cardiovascular disease 10 years		19. DUE TO, OR AS A CONSEQUENCE OF (b) 		20. DUE TO, OR AS A CONSEQUENCE OF (c) 	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 			
22a. I certify that (I) (this hospital) attended the deceased from 11-17-82 to 11-17-82 , that (I) (we) lost saw the deceased alive on 11-17-82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Daniel I Welliver MD		22c. DATE SIGNED 11-17-82		22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANIEL I WELLIVER MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/19/82		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		23d. LOCATION CITY OR TOWN Baltimore, COUNTY Maryland STATE 	
24. FUNERAL DIRECTOR NAME 1630 Edmondson Ave., Catonsville, MD ADDRESS Witzke Catonsville Funeral Home, P.A. 21228		25a. DATE REC'D. BY REGISTRAR NOV 19 1982		25b. REGISTRAR'S SIGNATURE John J. Connel			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 9 2 3 4	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) <i>Mary E. Elizabeth Leaman</i>						2a. DATE OF DEATH MONTH DAY YEAR <i>11 10 82</i>		2b. HOUR <i>4:05 A.M.</i>			
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>11 19 06</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>75</i> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Baltimore</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Carroll</i> MD.					
10. CITY OR TOWN OF DEATH <i>Westminster</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Carroll County Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <i>MD.</i>		13b. COUNTY <i>Carroll</i>		13c. CITY OR TOWN <i>Westminster</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>Apt R. 100 Charles St. 21157</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>George Koenig</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Smith</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>2 20-01-6319</i>		17. INFORMANT ADDRESS <i>Mrs Richard Schocker. New Windsor Somerset Ct.</i>							
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic Obstructive Pulmonary Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>years</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 DAY</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i> P.M.				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>11/9</i> 19 <i>82</i> , to <i>11/10</i> 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>11/10</i> 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Norman Goldstein</i>						DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>11/10/82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Norman Goldstein</i>						22e. ADDRESS <i>218 Washington Heights Med Center Westminster, Md. 21157</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>11-13-82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore City Md.</i>		
24. FUNERAL DIRECTOR <i>Thomas D. Fletcher & Son F.H.</i> <i>221 East Main Street Westminster, Md. 21157</i>						25a. DATE REC'D. BY REGISTRAR <i>NOV 12 1982</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Cahill</i>			

BP

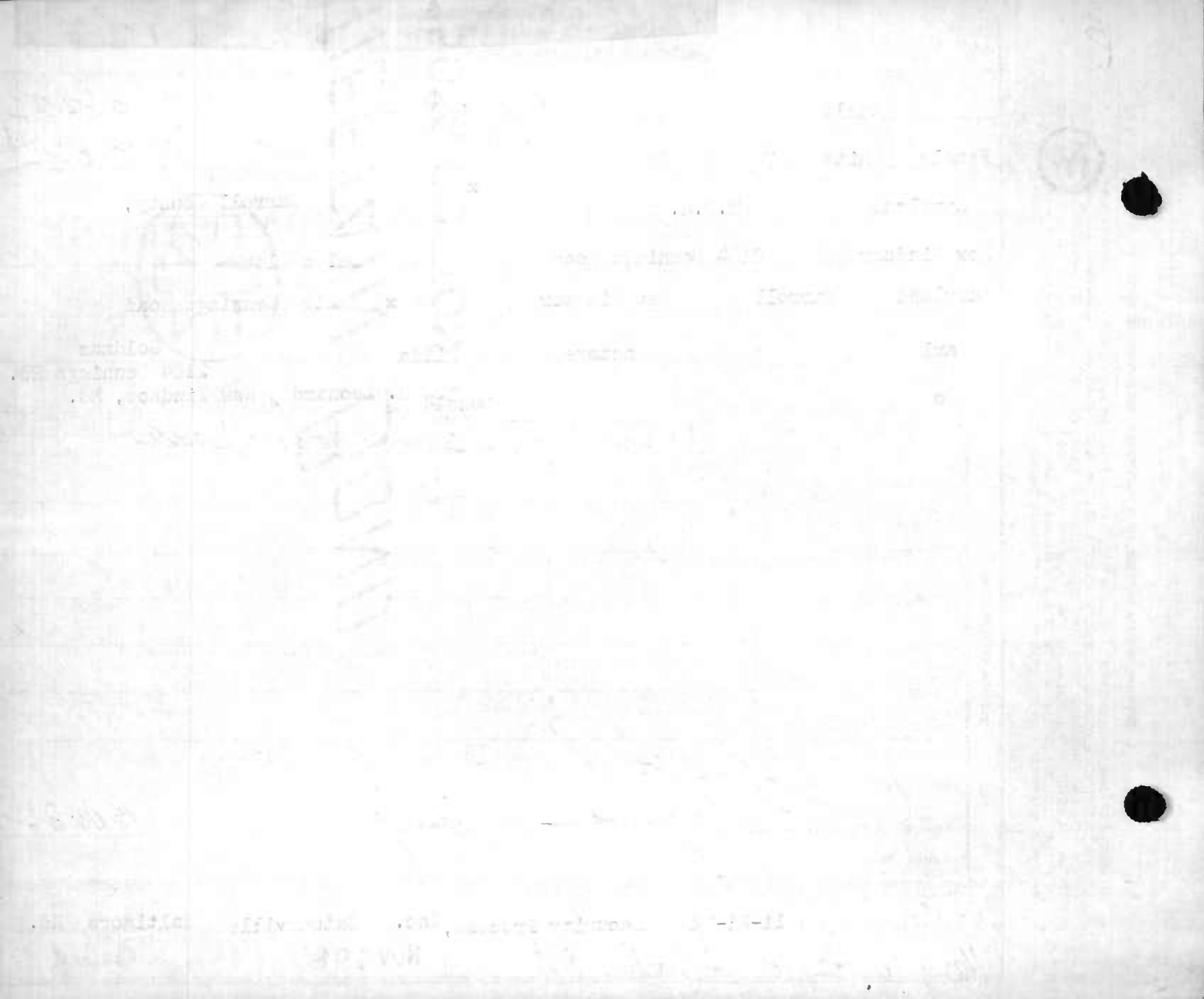


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH YOUR FILES, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

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(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 29235	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Adele						2a. DATE KNOWN OF DEATH		2b. DATE OF DEATH		2c. DATE OF DEATH	
3. SEX Female						4. RACE White		5. DATE OF BIRTH MONTH 7 DAY 2 YEAR 27		6. AGE (IN YEARS) LAST BIRTHDAY 55 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland						7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County, MD.	
10. CITY OR TOWN OF DEATH New Windsor						11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2184 Dennings Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Clerk	
13a. STATE Maryland						13b. COUNTY Carroll		13c. CITY OR TOWN New Windsor		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST Earl MIDDLE Santmyer LAST Hilda						15. MOTHER'S MAIDEN NAME FIRST Hilda MIDDLE Goldman LAST Goldman		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 4292						17. INFORMANT Donald H. Leonard		ADDRESS 2184 Dennings Rd. New Windsor, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic degenerative cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (b) 4292 DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion	
ACTUAL SIGNATURE [Signature]						TITLE (SPECIFY) [Signature]		MEDICAL EXAMINER		DATE SIGNED 18 Nov 82	
EXAMINER'S NAME (TYPE OR PRINT)						ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation						23b. DATE 11-21-82		23c. NAME OF CEMETERY OR CREMATORY Security Process Inc.		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Baltimore Md.	
24. FUNERAL DIRECTOR NAME Harry W. Haight ADDRESS Lyttonville, Md.						25a. DATE REC'D. BY REGISTRAR NOV 19 1982		25b. REGISTRAR'S SIGNATURE [Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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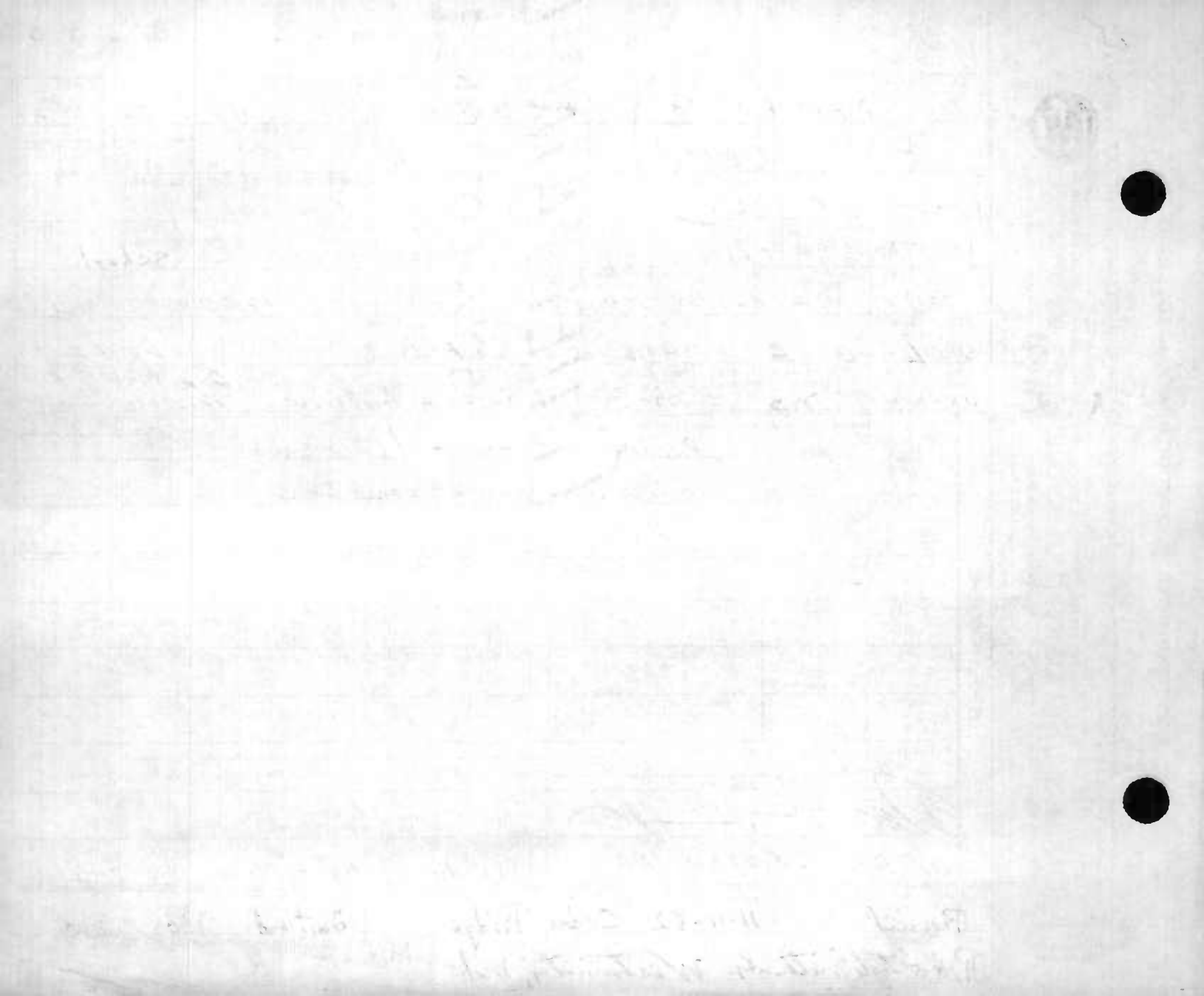
BP

DHMH - 16 50M 1/81
(VRA 15, 4)1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 2 3 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARTHA A. MAC DONALD			2a. DATE OF DEATH MONTH DAY YEAR 11 8 82			2b. HOUR 10 ²⁵ A M		
3. SEX F		4. RACE CAUC		5. DATE OF BIRTH MONTH DAY YEAR 9 3 1904		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 78		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH. D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.		
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL LUTHERAN VILLAGE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TEACHER		
12b. KIND OF BUSINESS OR INDUSTRY School								
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE MD.		13b. COUNTY CARROLL		13c. CITY OR TOWN WESTMINSTER		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET ADDRESS 1021 FRIDINGER MILL RD.								
14. FATHER'S NAME FIRST MIDDLE LAST ROLAND A. ADKINS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CLARA PRICE				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNKNOWN		16b. SOCIAL SECURITY NO. 219-349348		17. INFORMANT PATRICIA VANBRADLE		ADDRESS 202 PEGASUS RD. REISTERSTOWN, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) PNEUMONIA + ANOXIA (CHEMICAL) 4912 DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC + ACUTE BRONCHITIS DUE TO, OR AS A CONSEQUENCE OF (c) COPD APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.								
23a. SIGNATURE Dean Griffin M.D.				DEGREE		22c. DATE SIGNED		
24a. PHYSICIAN'S NAME (TYPE OR PRINT) DEAN GRIFFIN M.D.				22e. ADDRESS 19 Ridge Rd. Westminster, Md. 21157				
23a. BURIAL, CREMATION, REMOVAL (TYPE OF) Burial		23b. DATE 11-11-82		23c. NAME OF CEMETERY OR CREMATORY Cedar Ridge		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P. Co. Baltimore		
24. FUNERAL DIRECTOR Robert E. Griffiths Jr. Westminster, Md.				75a. THIS RECORD BY HEALTH DEPARTMENT SIGNATURE NOV 18 1982				



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 2 2 9 2 3 7				
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROSALINE DOROTHY MARKEY					2a. DATE OF DEATH MONTH DAY YEAR Nov 8, 1982			2b. HOUR 2:10 PM	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR JULY 14 1909		6. AGE (IN YEARS LAST BIRTHDAY) YRS 73		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.			
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL CO. HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEKEEPER		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
13a. STATE MARYLAND		13b. COUNTY CARROLL		13c. CITY OR TOWN WESTMINSTER		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 33 SULLIVAN RD.	
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS JONES				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSE FREY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 210-05-3334D		17. INFORMANT THOMAS H. JONES		ADDRESS WESTMINSTER MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 2396 IMMEDIATE CAUSE (a) Brain tumor DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Nov 1, 1982 , to Nov 8, 1982 , that (I) (we) lost saw the deceased alive on Nov 8, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John S. Harshey, MD				DEGREE MD				22c. DATE SIGNED 11/8/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN S. HARSHEY, MD				22e. ADDRESS 8 duchampt. Westminister, Md. 21157					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE NOV 11-1982		23c. NAME OF CEMETERY OR CREMATORY SMITHSBURG CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE SMITHSBURG MD			
24. FUNERAL DIRECTOR NAME D D Hartzler New Windsor, Md				DATE REC'D. BY REGISTRAR NOV 10 1982		25. REGISTRAR'S SIGNATURE John J. Gaird			

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 9 2 3 8			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST RUSSELL E. MARTIN				MONTH DAY YEAR 11-5-82			
3. SEX				2b. HOUR			
Male				5 P.M.			
4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
White		MONTH DAY YEAR 4 8 1906		76 YRS.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
Maryland		USA		9. BALTIMORE CITY OR COUNTY OF DEATH			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Hampstead		2704 Rohrbaugh Road		Carpenter			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.		Carroll		Hampstead		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS			
FIRST MIDDLE LAST Clarence Martin		FIRST MIDDLE LAST Bertie Armacost		2704 Rohrbaugh Road			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS			
no		217-16-4234		Mr. R. Irvin Martin, Hampstead, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION							
4100							
DUE TO, OR AS A CONSEQUENCE OF							
(b) CORONARY ART. DIS.							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
AORTIC STENOSIS & VALVE PROSTHESIS							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 98 to OCTOBER 19 82, that (I) (we) lost saw the deceased alive on OCTOBER 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
MANUEL J. SEVILLA				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
MANUEL J. SEVILLA				419 C MAZCOLM DR. WESTMINSTER			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		11-8-82		Mt. Zion Cemetery		CITY OR TOWN COUNTY STATE Upperco Balto Md.	
24. FUNERAL DIRECTOR				25. DATE REC'D. BY REGISTRAR			
NAME ADDRESS Eline Funeral Home, Hampstead, Md. 21074				NOV 8 1982 John J. Canfield			

BP



NOV 8 1985

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- STATE REGISTRAR MYRTLE H. MAUCK									
REG. NO. 8 2 2 9 2 3 9									
1. DECEASED NAME (TYPE OR PRINT) MYRTLE H. MAUCK						2a. DATE OF DEATH MONTH NOV. DAY 11 YEAR 82		7b. HOUR 6 55 M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH 4 DAY 08 YEAR 1914		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		IF UNDER 1 YEAR MONTHS - DAYS -	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL COUNTY MD.			
10. CITY OR TOWN OF DEATH SYKESVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION SPRINGFIELD HOSP. CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY -	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY WASHINGTON 13c. CITY OR TOWN HAGERSTOWN									
14. FATHER'S NAME FIRST WILLIAM MIDDLE H. LAST LL				15. MOTHER'S MAIDEN NAME FIRST SALLIE MIDDLE DALEY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 218-76-7779		17. INFORMANT Name Carl S. Eby ADDRESS Route #1 Box 452 Clear Spring, Md. 21722			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 2765 IMMEDIATE CAUSE (a) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) A.S.C.V.D. DUE TO, OR AS A CONSEQUENCE OF (c) Chronic dehydration + decubiti								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH few minutes years months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Polyploidy due to cerebral arteriosclerosis.									
19a. DATE OF OPERATION -		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12-08- 19 75 , to 11-2- 19 82 , that (I) (we) lost saw the deceased alive on 11-2- 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Jean M. Muddell				DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 11-2-1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAYAN S. ESENDAL M.D.				22e. ADDRESS SPRINGFIELD HOSP. CENTER					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-5-82		23c. NAME OF CEMETERY OR CREMATORY Clear Spring Mennonite		23d. LOCATION CITY OR TOWN Nr Clear Spring COUNTY Washington STATE MD			
24. FUNERAL DIRECTOR NAME AK. COFFMAN FUNERAL HOME INC ADDRESS HAGERSTOWN, MD				25a. DATE REC'D. BY REGISTRAR NOV 8 1982		25b. REGISTRAR'S SIGNATURE John J. Caruth			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5. FILES TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR										2 2 9 2 4 0									
1. DECEASED NAME (TYPE OR PRINT) George H. McComas										2a. DATE KNOWN OF DEATH 11 24 1982									
3. SEX Male		4. RACE White		5. DATE OF BIRTH 10 24 97		6. AGE (IN YEARS) 85 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD 11 24 1982		2b. HOUR 1:30 P. M.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County, MD.							
10. CITY OR TOWN OF DEATH Hampstead				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1/2 mile North of Rt. 482 on Rt. 30						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer				12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Maryland				13b. COUNTY Carroll		13c. CITY OR TOWN Hampstead		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 5000 Maple Grove Road									
14. FATHER'S NAME George						15. MOTHER'S MAIDEN NAME Mary J. Martin													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 214-30-1838				17. INFORMANT ADDRESS Mr. Sterling Alban, Manchester, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Injuries</u> <u>8120</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOURS <u>12:40</u> MONTH <u>11</u> DAY <u>24</u> YEAR <u>1982</u>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) driver in auto/auto collision											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road				21f. LOCATION STREET North of Rt. 482 on Rt. 30, Hampstead, Carroll Co., Md.											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>				TITLE (SPECIFY) Assistant MEDICAL EXAMINER						DATE SIGNED 11-25-82									
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn Street															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 11-28-82		23c. NAME OF CEMETERY OR CREMATORY Grace Cemetery				23d. LOCATION CITY OR TOWN Upperco COUNTY Balto STATE Md.									
24. FUNERAL DIRECTOR NAME Eline Funeral Home, Hampstead, Md. 21074						25a. DATE REC'D BY REGISTRAR NOV 30 1982		25b. REGISTRAR'S SIGNATURE <i>John J. Carver</i>											

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE

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FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE



NOV 20 1963

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 9 2 4 1	
1 - FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elner Amanda McCoy						2a. DATE OF DEATH MONTH DAY YEAR 11 14 82		2b. HOUR 0049AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 21, 1897		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 85 1 23		IF UNDER 1 YEAR IF UNDER 24 HRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll Co., MD					
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Co. General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland 13b. COUNTY Carroll 13c. CITY OR TOWN Sykesville						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 6041 Old Washington Rd.			
14. FATHER'S NAME FIRST MIDDLE LAST Amos J. Brakeall				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emeline Barber							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 219-22-2134		17. INFORMANT ADDRESS Mrs. Edwina A. Thrift, Same As #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4275 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Pneumonia. Cerebrovascular insufficiency											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 11-12-1982 to 11-14-1982 , that (I) (we) last saw the deceased alive on 11-13-1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE CHITRAKETHU NAGANNA				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 11/14/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHITRAKETHU NAGANNA				22e. ADDRESS 174 E Main St Westminster MD 21157							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-17-1982		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville, Baltimore, Md.					
24. FUNERAL DIRECTOR NAME ADDRESS Charles W. Burrier, Jr., Sykesville, Md.						25a. DATE REC'D. BY REGISTRAR NOV 16 1982		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

BP



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 2 4 2

1- FOR
STATE
REGISTRAR

REG. NO.

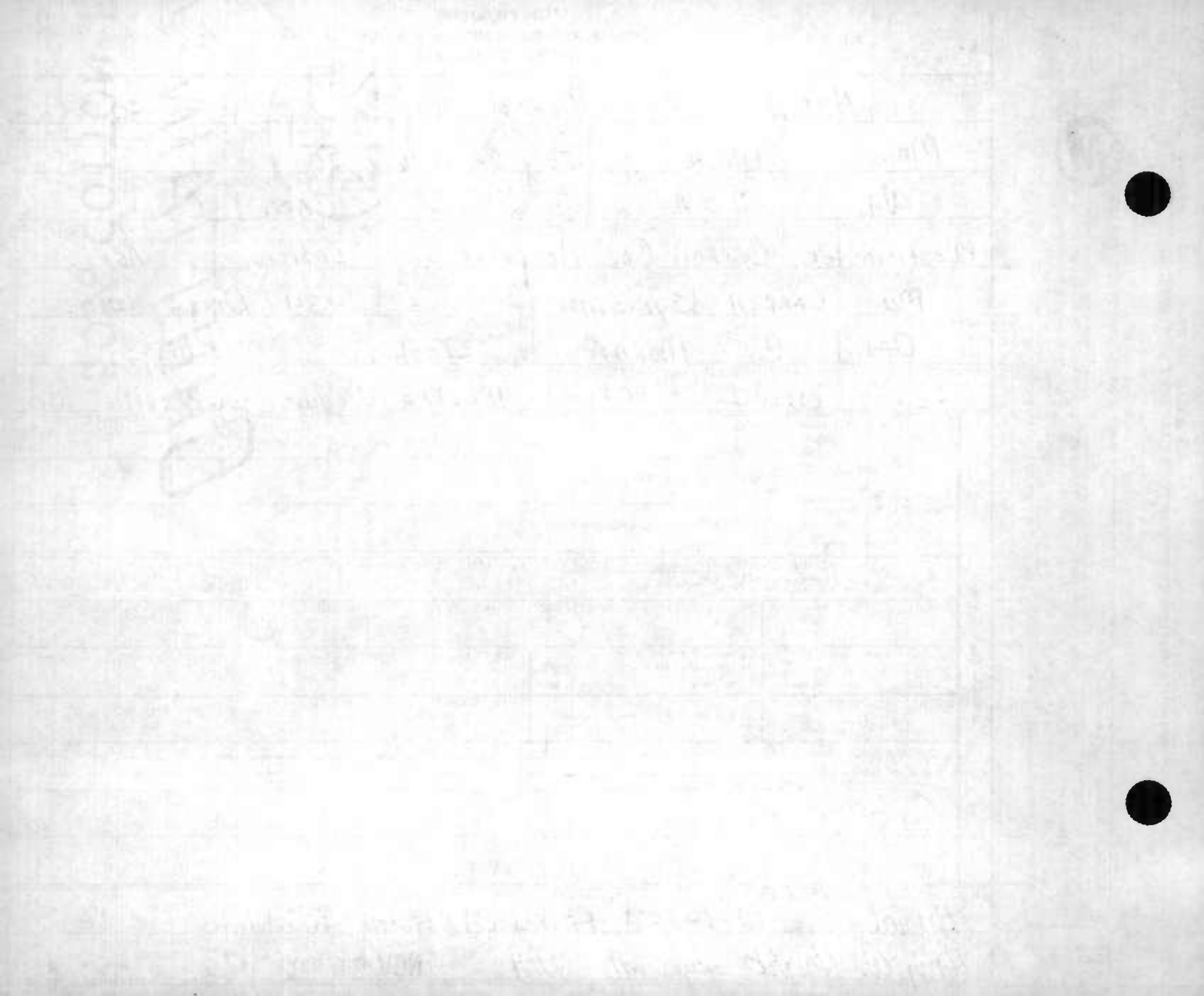
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Anton K. MORAN			2a. DATE OF DEATH MONTH DAY YEAR 11-28-82		2b. HOUR 1205
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 28, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL County MD.	
10. CITY OR TOWN OF DEATH Westminster	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL Co. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY AGRI.
13a. STATE Md.			13b. COUNTY CARROLL	13c. CITY OR TOWN Sykesville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST David C. MORAN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jesten Phipps		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) unk.		17. INFORMANT ADDRESS MARTHA Woodie Sykesville, Md	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1629 bronchogenic carcinoma DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) cerebrovascular accident and Arterioelectric Heart Disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10-31-1982 , to 11-28-1982 , that (I) (we) last saw the deceased alive on 11-28-1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE CHATRACHEDU NAGANNA		DEGREE MD		22c. DATE SIGNED 11/28/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 174 E. Main St Westminster MD 21157			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-1-82		23c. NAME OF CEMETERY OR CREMATORY Fairwood Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Troutdale VA.					
24. FUNERAL DIRECTOR NAME ADDRESS Harry W. Haight Sykesville, Md.				25a. DATE REC'D. BY REGISTRAR NOV 29 1982	
				25b. REGISTRAR'S SIGNATURE John J. Carver	

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BP



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DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 2 4 3

FOR
1. STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) BILLIE Lewis NEWMAN			2a. DATE OF DEATH MONTH DAY YEAR 11-18-82		2b. HOUR 6:20 PM
3. SEX Fe	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 7-10-09		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) TEXAS	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL Co. MD.	
10. CITY OR TOWN OF DEATH SYKESVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SPRINGFIELD Hosp Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Teacher		12b. KIND OF BUSINESS OR INDUSTRY Pub. Schools
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY CARROLL		13c. CITY OR TOWN Union Bridge
14. FATHER'S NAME FIRST MIDDLE LAST SEBE NEWMAN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca WHITFALL		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-38-3281-1		17. INFORMANT ADDRESS Hosp Record	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1519 IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (b) Gastric Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE JoE M PARK		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 11-18-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOE M PARK		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 20, 1982		23c. NAME OF CEMETERY OR CREMATORY Flint Hill Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Oakton, Fairfax Co., Va.		23e. DATE REC'D. BY REGISTRAR NOV 29 1982			
24. FUNERAL DIRECTOR NAME Money & King Funeral Home 171 W. Maple Ave., Vienna, Va. 22180		25. REGISTRAR'S SIGNATURE John J. Carver			

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 2 4 4

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MINNIE Muller PORTER			2a. DATE OF DEATH MONTH DAY YEAR 11 / 1, 1982			2b. HOUR 8:30 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 1, 1893		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		7. GENDER 1 YEAR MONTHS DAYS 9 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll Co., MD.			
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Westminster Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 928 Muller Rd.	
14. FATHER'S NAME FIRST LAST Henry J. Muller					15. MOTHER'S MAIDEN NAME FIRST LAST Rachel K. Wagner				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 213-38-9748D			17. INFORMANT ADDRESS Westminster, Md. Hilda L. Porter, 89 Bond St.			
18. CAUSE OF DEATH (Enter only one cause and line for each (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE: Coronary atherosclerotic cardiovascular disease 4292 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause: (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Severe Osteoarthritis									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT HOME			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/27 19 81 to Nov 1st 19 82 , that (I) (we) last saw the deceased alive on 10/24 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
23a. SIGNATURE Richard D. Bynple			23b. PHYSICIAN'S NAME (LAST OR PRINT) Richard D. Bynple			23c. DATE SIGNED 11/1/82		23d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> 112 CARROLL PLAZA WESTMINSTER, MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11-4-1982			23c. NAME OF CEMETERY OR CREMATORY Salem		23d. LOCATION CITY OR TOWN COUNTY STATE Carroll, Md.	
24. FUNERAL DIRECTOR NAME Charles W. Burrier, Jr., Sykesville, Md.						25a. DATE REC'D. BY REGISTRAR NOV 4 1982		25b. REGISTRAR'S SIGNATURE Joan J. Corneil	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

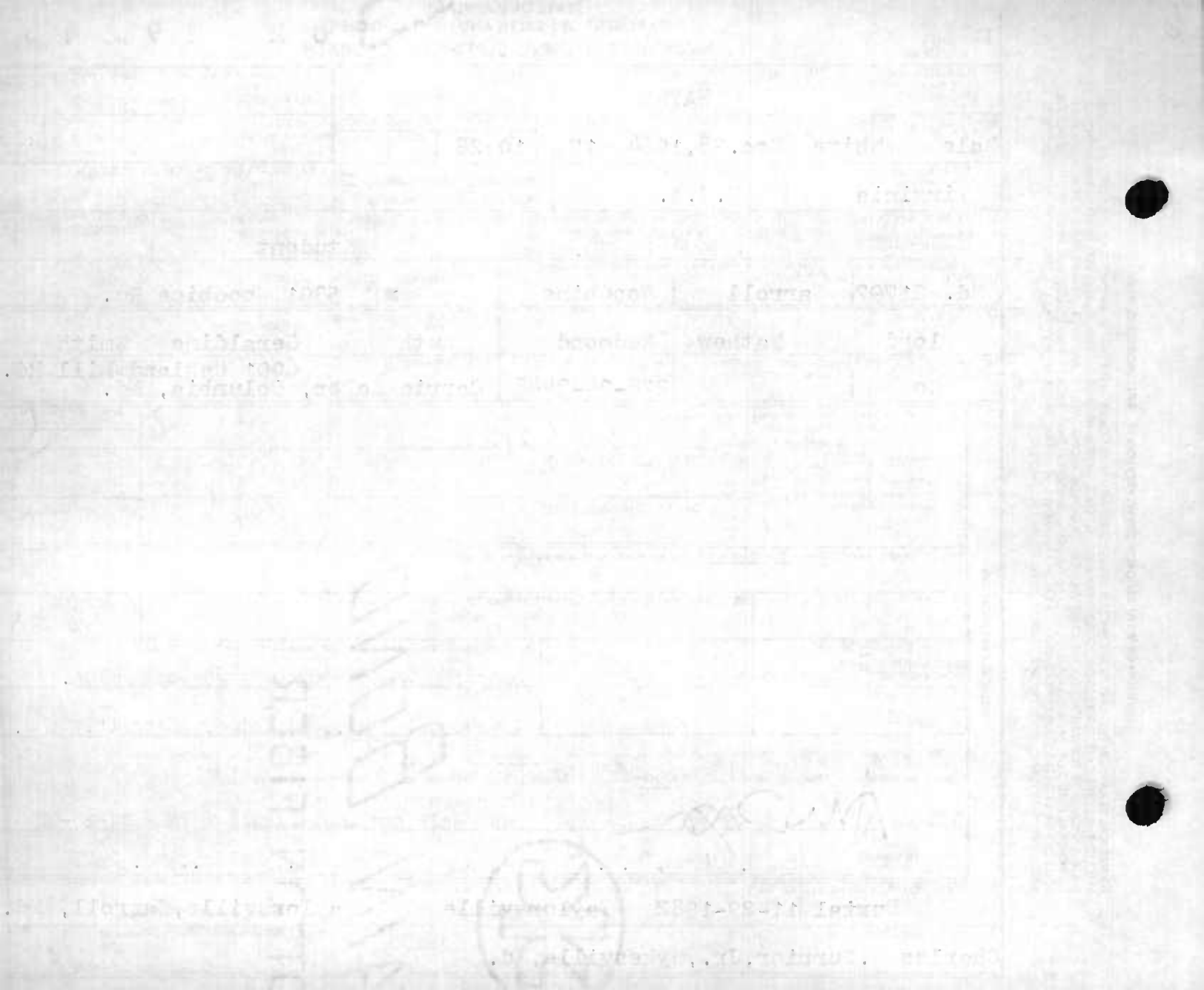
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of page.

11-1-85

REG. NO.

MEDICAL CERTIFICATION

20M 4/82



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 2 4 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Alma Sheckels Rodgers			2a. DATE OF DEATH MONTH DAY YEAR November 15, 1983			2b. HOUR 0826 M					
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 10 10 14		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.					
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Co. Gen. Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. STATE Md			13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1040 Hemlock Lane		
14. FATHER'S NAME FIRST MIDDLE LAST Allan Sheckels				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Spates							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) n/a		17. INFORMANT 21980 7508		17. ADDRESS Patricia Benson Annapolis, Md 21012					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiogenic Shock</u> <u>4292</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 8</u> , 19 <u>82</u> , to <u>Nov 15</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>Nov 15</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>John S. Harshey, MD</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/15/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN S. HARSHEY, MD.						22e. ADDRESS 8 Anchor St. Westminster, Md. 21157					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/17/82		23c. NAME OF CEMETERY OR CREMATORY Meadow Branch			23d. LOCATION CITY OR TOWN COUNTY STATE Westminster Carroll Md			
24. FUNERAL DIRECTOR NAME ADDRESS PRITTS FUNERAL HOME WESTMINSTER, MD 21157						25a. DATE REC'D. BY REGISTRAR NOV 22 1982					
						25b. REGISTRAR'S SIGNATURE <u>John J. Smith</u>					



X

NOV 2 1985

STATE OF MARYLAND

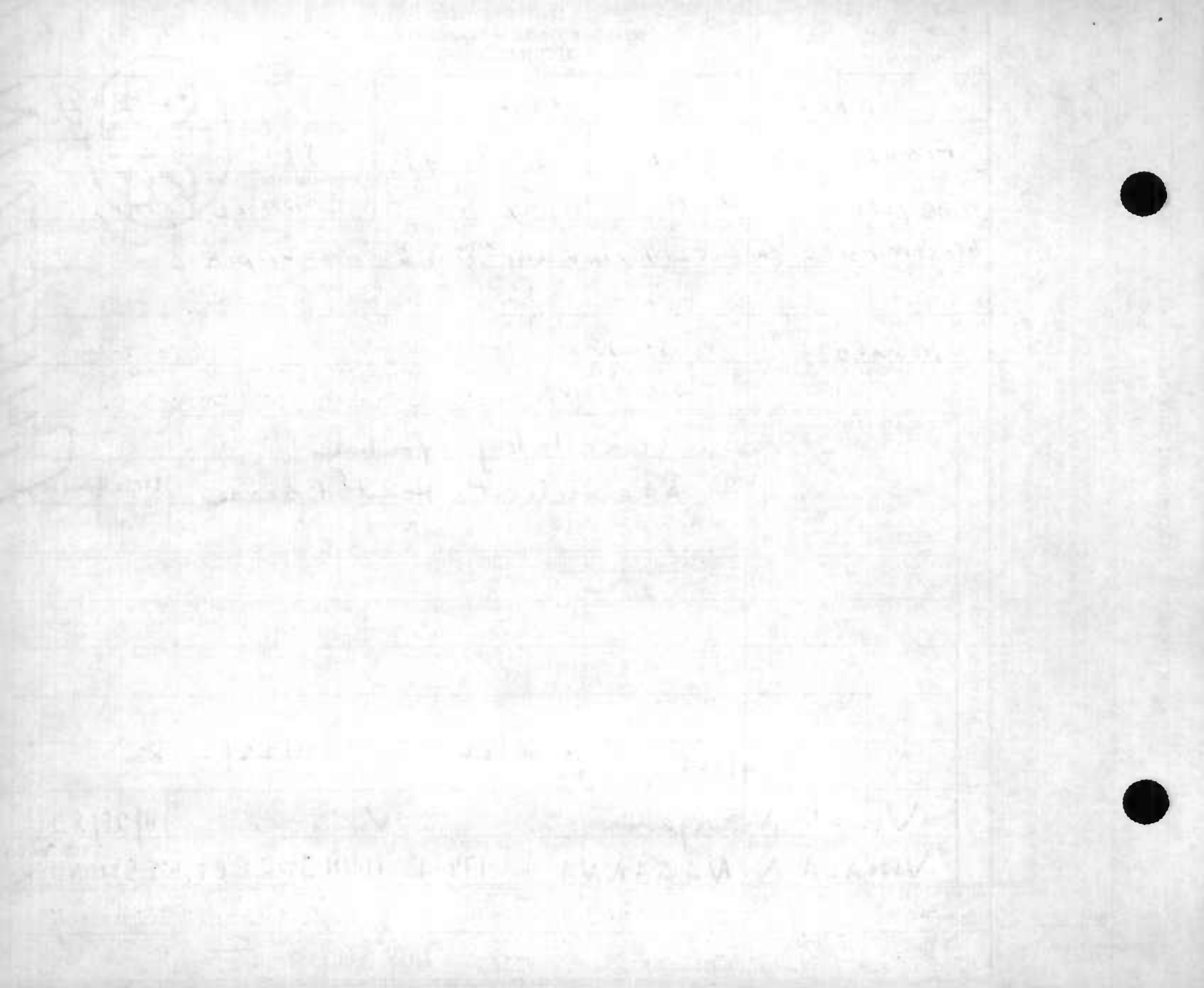
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE C LAST RUSH			2a. DATE OF DEATH MONTH DAY YEAR 11 28 82		2b. HOUR 4 AM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 2 6 93		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL County MD.	
10. CITY OR TOWN OF DEATH Westminster	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL LUTHERAN Village Health Care Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Book Keeper	12b. KIND OF BUSINESS OR INDUSTRY --	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY --- 13c. CITY OR TOWN Baltimore 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 3939 Roland Ave. 21211					
14. FATHER'S NAME FIRST HOWARD MIDDLE C LAST Stearns		15. MOTHER'S MAIDEN NAME FIRST Lillie MIDDLE M LAST Cadwallader			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. 216-03-5896	17. INFORMANT Sykesville		ADDRESS MD 21784	
		Campion W. Rush Jr		6605 Monroe Ave.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) circulatory failure DUE TO, OR AS A CONSEQUENCE OF: (b) Atherosclerotic Heart disease More than 10 years DUE TO, OR AS A CONSEQUENCE OF: (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1a					
9a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4/30/82 19 to 11/28/82 19 82, that (I) (we) lost saw the deceased alive on 4/12/82 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Vimala N. Naganna		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/28/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VIMALA N. NAGANNA		22e. ADDRESS 174 E. MAIN STREET, WESTMINSTER MD 21157			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11/30/82	23c. NAME OF CEMETERY OR CREMATORY Mt. Olive		23d. LOCATION CITY OR TOWN COUNTY STATE Randallstown Baltimore MD	
24. FUNERAL DIRECTOR Loring Byers Funeral Directors, Inc		25a. DATE REC'D. BY REGISTRAR NOV 30 1982		REGISTRAR'S SIGNATURE John J. Calver	
8728 Liberty Rd.		Randallstown, Md. 21133			

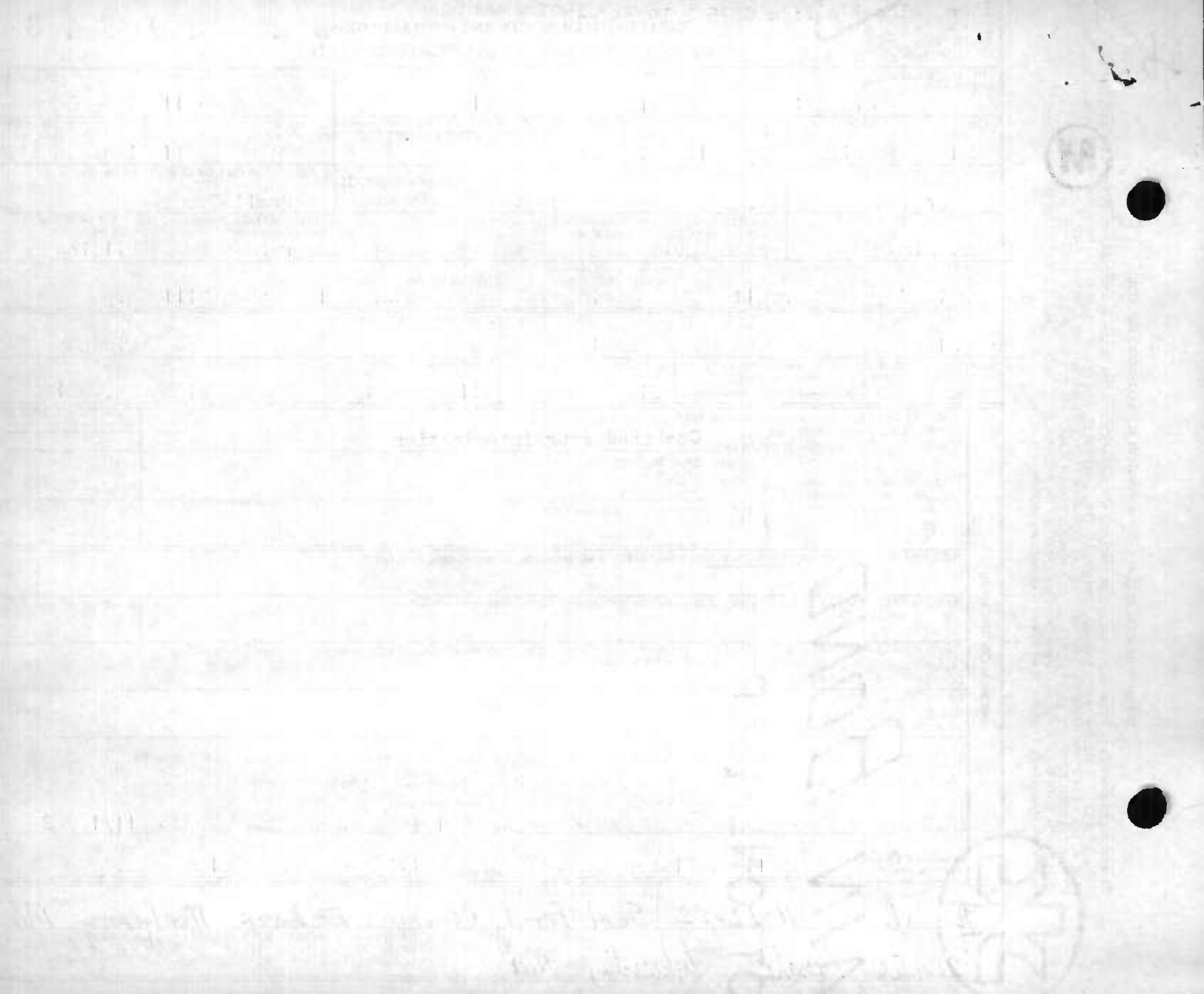


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. FOR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH THE WORKS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
20M 4/82

DEPARTMENT OF HEALTH AND MENTAL HYGIENE										REG. NO.	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Michael Kevin Seal										2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input checked="" type="checkbox"/> 11 15 19 82	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 17 61		6. AGE (IN YEARS LAST BIRTHDAY) 21 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County, MD		2d. DATE PRONOUNCED DEAD 11 15 19 82	
10. CITY OR TOWN OF DEATH Mt. Airy		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6332 Davis Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Building		2d. HOUR 8:15A	
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Woodbine		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 149 Hoods Mill Rd.			
14. FATHER'S NAME FIRST MIDDLE LAST Claude H. Seal				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mae M. Minor							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 215-88-7454		17. INFORMANT Claude Seal		ADDRESS Woodbine, Md. 21797			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 94779 IMMEDIATE CAUSE (a) Combined drug intoxication Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Russell S. Fisher				TITLE (SPECIFY) M.D. Chief				DATE SIGNED 11/17/82			
EXAMINER'S NAME (TYPE OR PRINT) Russell S. Fisher, M.D.				ADDRESS 111 Penn St. Balto., Md.							
23a. BURIAL, CREMATION, REMOVAL Burial				23b. DATE 11-17-82		23c. NAME OF CEMETERY OR CREMATORY Seal Family Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE E. Hines Montebello Md.			
24. FUNERAL DIRECTOR NAME Harry W. Knight				ADDRESS Sykesville, Md.		25a. DATE REC'D. BY REGISTRAR NOV 18 1982		25b. REGISTRAR'S SIGNATURE John J. [Signature]			

BP 396



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 2 9 2 4 9			
1- FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Walter L. Seipp				2a. DATE OF DEATH MONTH DAY YEAR November 15, 1982		2b. HOUR 1341 M	
3 SEX male		4 RACE white		5. DATE OF BIRTH MONTH DAY YEAR 4 26 05		6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 77 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.	
10 CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL CO. GENERAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABOR		12b KIND OF BUSINESS OR INDUSTRY GARAGE	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD.				13b COUNTY CARROLL		13c CITY OR TOWN WESTMINSTER	
14 FATHER'S NAME FIRST MIDDLE LAST SAMUEL SEIPP				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JENNIE DEAGAN			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NONE		17. INFORMANT ADDRESS FLORENCE SEIPP 13e 21157			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 11/15 , 19 82 , to 11/15 , 19 82 , that (I) (we) lost saw the deceased alive on 11/15 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE John S. Harshey, M.D. DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/15/82	
22d PHYSICIAN'S NAME (TYPE OR PRINT) JOHN S. HARSHEY, M.D.				22e ADDRESS 8 Anchor St. Westminster, Md. 21157			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 11-18-82		23c NAME OF CEMETERY OR CREMATORY WESTMINSTER		23d. LOCATION CITY OR TOWN COUNTY STATE WESTMINSTER CARROLL MD.	
24 FUNERAL DIRECTOR PRITTS FUNERAL HOME WESTMINSTER, MD.				25a DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE NOV 22 1982 John J. Canfield			

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NOTE: THE FOLLOWING INFORMATION IS FOR INFORMATION ONLY

ALCOHOL 100

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 2 5 0

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST Nova		MIDDLE M		LAST Sharrer		2a. DATE OF DEATH		MONTH 11		DAY 1		YEAR 82		2b. HOUR 12 ¹⁵ AM	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH		MONTH 11		DAY 13		YEAR 1892		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS 89 YRS.		IF UNDER 24 HRS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.													
10. CITY OR TOWN OF DEATH Manchester		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Long View Nsg. Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House wife		12b. KIND OF BUSINESS OR INDUSTRY NONE													
13a. STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Ladiesburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 21759 12509 B WOODBORO PIKE											
14. FATHER'S NAME		FIRST Robert		MIDDLE		LAST Beall		15. MOTHER'S MAIDEN NAME		FIRST ALMA		MIDDLE ELIZABETH		LAST Poole					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-74-4034		17. INFORMANT Louise Bollinger		ADDRESS Westminster, Md.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:																			
4140 IMMEDIATE CAUSE (a) Congestive Heart Failure																		1 day	
DUE TO, OR AS A CONSEQUENCE OF																			
(b) Arteriosclerotic Heart Disease																		5 yrs	
DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that (I) (this hospital) attended the deceased from 3 (16) 1982 to Nov 1 1982, that (I) (we) last saw the deceased alive on Oct 31 - 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE W. H. Foard MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/1/82													
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W H Foard MD		22e. ADDRESS 3223 Main St Box E Manchester MD 21102																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 11-4-82		23c. NAME OF CEMETERY OR CREMATORY MT. TABOR LUTH. CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE ROCKY RIDGE FRED. MD.													
24. FURNERAL DIRECTOR Robert E. Dancy 408		25. DATE REC'D. BY REGISTRAR NOV 8 1982		25. REGISTRAR'S SIGNATURE John J. Connel															

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100
2
2
9

1. The medical examiner must be notified by the funeral director, page 4 of this form, within 72 hours after death. The low requires that the death certificate be executed within 24 hours after death. Page 4 of this form should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by page 4.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 of this form should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by page 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 of this form should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by page 4.

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 2 5 1

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mary Irene SIBIEY			2a. DATE OF DEATH MONTH DAY YEAR Nov 1 82			2b. HOUR 9⁰⁰ P^M	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 7 28 91		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.	
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WNC		12a. USUAL OCCUPATION (TYPE WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY Balto.		13c. CITY OR TOWN Owings Mills		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Sebastian Long		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Reinecke		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-34-6672	
17. INFORMANT Jan Ford		ADDRESS 65 W. Green St. 21157		18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) <u>Arteriosclerotic CV Disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7-14 , 19 76 , to 11-1 , 19 82 , that (I) (we) last saw the deceased alive on 11-1 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE C.E. McWilliams		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11-2-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C.E. McWilliams		22e. ADDRESS 11904 Ruxton Rd, Ruxton Md. 21136					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE Nov. 4, 1982		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.		23d. LOCATION CITY/TOWN COUNTY STATE Pikesville, Balto., Md.	
24. FUNERAL DIRECTOR NAME H. J. Echhardt		ADDRESS Owings Mills, Md		25a. DATE REC'D. BY REGISTRAR NOV 5 1982		REGISTRAR'S SIGNATURE John J. Ganiel	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
<div style="text-align: right;">8 2 2 9 2 5 2</div> <div style="text-align: center;"> CERTIFICATE OF DEATH REG. NO. </div>									
1. DECEASED NAME (TYPE OR PRINT) John William Smith					2a. DATE OF DEATH MONTH DAY YEAR 11 30 82		2b. HOUR 0110 AM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 14 1905		6. AGE (IN YEARS LAST BIRTHDAY) 77		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore County		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.			
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Scheffer Lumber Company		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland					13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST William H. Smith					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Irene Dell				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 219-05-7982		17. INFORMANT Westminster, Md. 21157 Virginia Harris 832 Regent St.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory failure 4149 DUE TO, OR AS A CONSEQUENCE OF: (b) congestive heart failure DUE TO, OR AS A CONSEQUENCE OF: (c) coronary artery disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11-26 , 19 82 , to 11-30 , 19 82 , that (I) (we) last saw the deceased alive on 11-30 , 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Juan A. Surriel M.D.						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 11-30-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JUAN A. SURIEL, M.D.						22e. ADDRESS CARROLL CO. GEN. HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-3-82		23c. NAME OF CEMETERY OR CREMATORY Finksburg Church Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Finksburg Carroll Md.		
24. FUNERAL DIRECTOR NAME Thomas D. Fletcher & Son F.H. 254 East Main Street Westminster, Md. 21157						25a. DATE REC'D. BY REGISTRAR DEC 6 1982			
25b. REGISTRAR'S SIGNATURE John J. Conner									

BP

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

TO : DIRECTOR, FBI (100-371101)
FROM : SAC, NEW YORK (100-100000) (P)
SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

[Illegible]

[Illegible]

[Illegible]

100-371101-100000
DEC 1 1964
FBI NEW YORK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

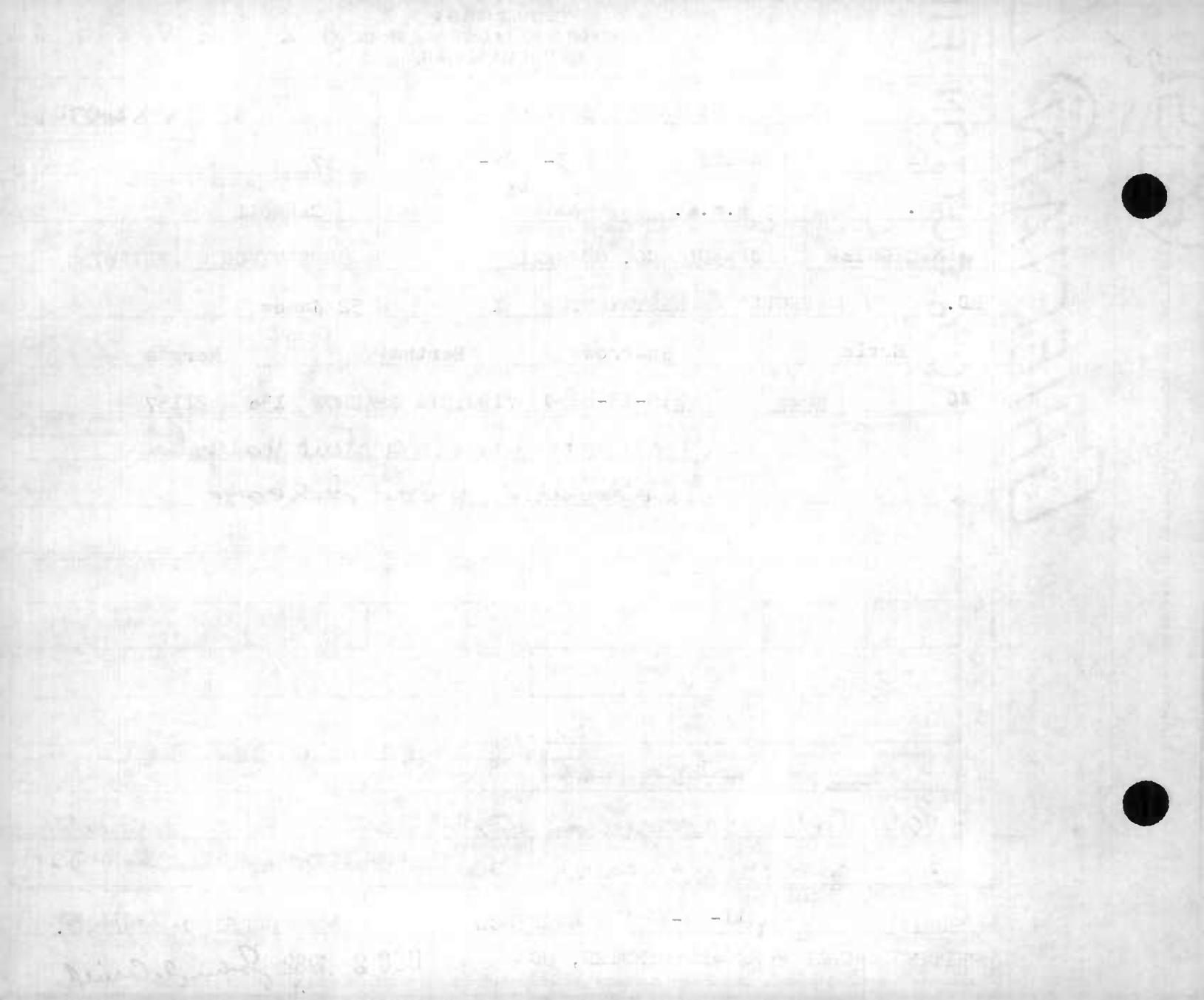
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of course.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					8 2 2 9 2 5 3 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST COLIE JACKSON SPARROW					2a. DATE OF DEATH MONTH DAY YEAR 11-26-82					2b. HOUR 0740M
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 3-24-1925		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.				
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL CO. GENERAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SUPERVISOR		12b. KIND OF BUSINESS OR INDUSTRY BUILDING		
13a. STATE MD.		13b. COUNTY CARROLL		13c. CITY OR TOWN WESTMINSTER		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 52 James		
14. FATHER'S NAME FIRST MIDDLE LAST Ervin Sparrow					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Morgan					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NONE		17. INFORMANT 215-12-8270		ADDRESS VIRGINIA SPARROW 13e 21157				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: 3989 IMMEDIATE CAUSE (a) Intractable congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Rheumatic Heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 11-8-19-82 to 11-26-19-82 that (I) (we) lost saw the deceased alive on 11-25-19-82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.										
22b. SIGNATURE Chitrahedu Naganna MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11/26/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHITRAHEDEU NAGANNA					22e. ADDRESS 174 E. Main St. Westminister MD 21157					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 11-29-82		23c. NAME OF CEMETERY OR CREMATORY PROVIDENCE		23d. LOCATION CITY OR TOWN COUNTY STATE WESTMINSTER CARROLL MD.				
24. FUNERAL DIRECTOR PRITTS FUNERAL HOME WESTMINSTER, MD					25a. DATE REC'D. BY REGISTRAR DEC 2 1982					
					25b. REGISTRAR'S SIGNATURE John J. Canfield					

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 2 5 4

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CELIA ALICE STRINE			2a. DATE OF DEATH MONTH DAY YEAR 11-3-82		2b. HOUR 10:15 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 9-28-1890		6. AGE (IN YEARS LAST BIRTHDAY) 92	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Fredrick County	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.	
10. CITY OR TOWN OF DEATH Westminster	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Westminster Nursing Center			12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY Carroll 13c. CITY OR TOWN Westminster			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 26 Timber Ridge Dr. 21157	
14. FATHER'S NAME FIRST MIDDLE LAST Reuben Bohn		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Heart			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-74-2413		17. INFORMANT ADDRESS Nevia L. Strine 254 E. Main St. Westminster Md. 21157	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

4292

IMMEDIATE CAUSE (a) **Atherosclerotic cardiovascular disease**

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Coronary Heart Failure.

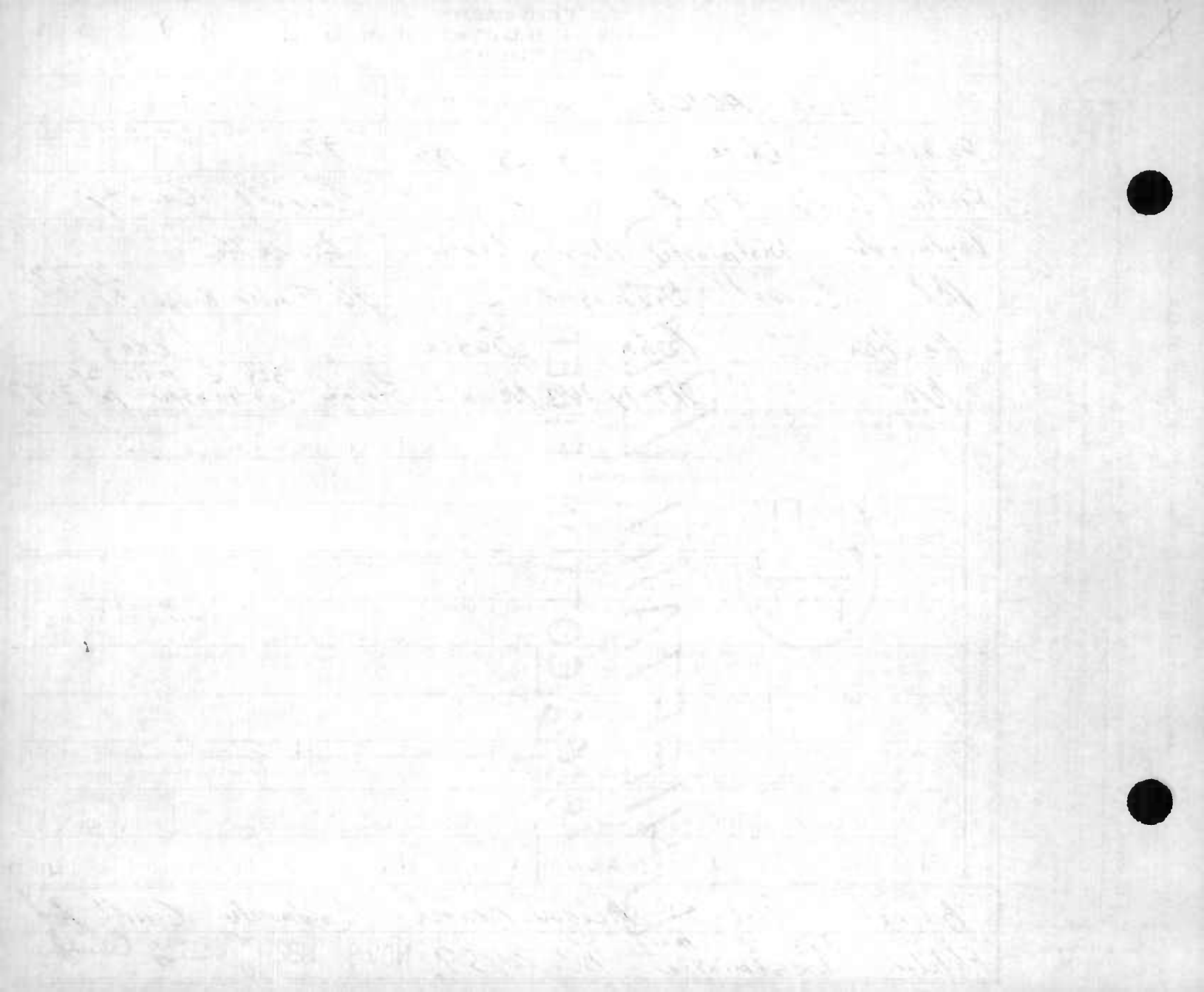
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11-27-1982 to 11-3-1982 , that (I) (we) last saw the deceased alive on 11-3-1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE CHITRA CHITTEDU NAGANNA		DEGREE MD			22c. DATE SIGNED 11/3/82
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 174 E. Main St. Westminster MD 21157			

23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial	23b. DATE 11-6-82	23c. NAME OF CEMETERY OR CREMATORY Meadow Branch	23d. LOCATION CITY OR TOWN COUNTY STATE Westminster Carroll Md.
24. FUNERAL DIRECTOR NAME Fletcher		25a. DATE REC'D. BY REGISTRAR NOV 8 1982	25b. REGISTRAR'S SIGNATURE John J. Cunniff

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 1.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 9 2 5 5

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR		A	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		11 8 82		6		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Male		White		MONTH DAY YEAR 4 24 13		69		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.	
Virginia		U.S.A.				Carroll			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Union Bridge		1401 McKinstry Mill Rd.		painter		house			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		Carroll		Union Bridge		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1401 McKinstry Mill Rd.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
Christian		Switzer		Mary		Susan		Higgs	
No		none		220-05-7841		Esther P. Switzer		Union Bridge, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		1579		DUE TO, OR AS A CONSEQUENCE OF		Carcinomatosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)		DUE TO, OR AS A CONSEQUENCE OF		pancreatic cancer		2 months	
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		ASCVD; ASPIRATION; INTESTINAL obstruction							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1-31 1975 to 11-8 1982 that (I) (we) last saw the deceased alive on 11-8 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
Ephraim Barzaga		MD - ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		11-8-82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE RECEIVED BY REGISTRAR		22g. REGISTRAR'S SIGNATURE			
Ephraim BARZAGA		NEW WINDSOR, Md. 21776		NOV 9 1982		John J. Conner			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		11/11/82		Evergreen Memorial Gardens		Finksburg Carroll Md.			
24. FUNERAL DIRECTOR		24a. ADDRESS		24b. DATE RECEIVED BY REGISTRAR		24c. REGISTRAR'S SIGNATURE			
D. K. Schuler		Union Bridge, Md.		NOV 9 1982		John J. Conner			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHM - 16 50M 1/76
(VR A 15 (4))

M

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 9 2 5 6			
1. FOR STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Clarence W. Wagner</u>						2a. DATE OF DEATH MONTH DAY YEAR <u>NOV 22 1982</u>				2b. HOUR <u>16 PM</u>			
3. SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>11 13 1892</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>90 YRS.</u>		7. IF UNDER 1 YEAR MONTHS DAYS <u>90 YRS.</u>		7. IF UNDER 24 HRS. HOURS MIN. <u>16 PM</u>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>CARROLL</u> MD.							
10. CITY OR TOWN OF DEATH <u>Westminster</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Westmr. Nrsng & Conval. Center</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Farmer</u>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>Maryland</u>						13b. COUNTY <u>Carroll</u>		13c. CITY OR TOWN <u>Hampstead</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <u>George F. Wagner</u>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Rebecca Leppo</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u>				16b. SOCIAL SECURITY NO. <u>214-20-5348</u>		17. INFORMANT ADDRESS <u>Mr. Robert W. Wagner, Mt. Airy, Md.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SEPSIS</u> <u>1850</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARCINOMA OF PROSTATE ADENOMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>H.S.C.V.D.</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u> <u>ADAM 3 YEARS</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>7/26 1982</u> to <u>11/22 1982</u> , that (I) (we) saw the deceased alive on <u>11/22 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.													
22b. SIGNATURE <u>Daniel J. Welliver M.D.</u>						DEGREE <u>M.D.</u>		22c. DATE SIGNED <u>11-22-82</u>		22d. ADDRESS <u>215 WASHINGTON HEIGHTS WESTMINSTER MARYLAND</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				23b. DATE <u>11-26-82</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Mem. Gardens</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Finksburg Carroll Md.</u>		25a. DATE REC'D. BY REGISTRAR <u>NOV 24 1982</u>			
24. FUNERAL DIRECTOR NAME <u>Eline Funeral Home, Hampstead, Maryland 21074</u>				25b. REGISTRAR'S SIGNATURE <u>Rea</u>									

SPPL & C VDM

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ANTICIPATED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (1))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			XX MONTH DAY YEAR			2b. HOUR			
Arthur R. Walsh						11 11 1982			10:46 a.						
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		2d. HOUR			
Male		White		10 7 1915		67 YRS.				11 11 1982		10:46 a.			
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland				USA								Carroll County, MD.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Westminster				Carroll County General Hospital				Farmer & Saw Mill Operator							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
Md.		Carroll		Hampstead		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3311 Shiloh Road							
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST						FIRST MIDDLE LAST									
Nicholas J. Walsh						Cordelia Millender									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
no						217-36-4712		Mrs. Susie Walsh, Hampstead, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															
PART I DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) Asphyxia															
9180															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.															
(b) DUE TO, OR AS A CONSEQUENCE OF															
(c) DUE TO, OR AS A CONSEQUENCE OF															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?			
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
				9:30 P.M. 11 11 1982				subject was trapped in machinery							
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION							
WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				Saw Mill				3311 Shiloh Road, Hampstead, Carroll Co., Md.							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED							
Dennis F. Smyth, M.D.				Assistant MEDICAL EXAMINER				11-12-82							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS											
Dennis F. Smyth, M.D.				111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION					
Burial				11-15-82		Shiloh Cemetery				Hampstead Carroll Md.					
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Eline Funeral Home, Hampstead, Md. 21074				NOV 15 1982				John J. Connelley							

MEDICAL CERTIFICATION

STANDARD INDUSTRIAL PAPER CO.
MADE IN U.S.A. 100% PAPER

OLSON 1185B

NOV 10 1964



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		8 2 2 9 2 5 8									
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Eva. May		11 11 82		0530							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
Female		White		Dec. 14, 1909		72 YRS		9 MONTHS 9 DAYS		27 HOURS	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9b. CITIZEN OF WHAT COUNTRY?		10. MARRIED		11. NEVER MARRIED		12. DIVORCED		13. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		U.S.A.		WIDOWED <input checked="" type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		Carroll Co., MD	
14. CITY OR TOWN OF DEATH		15. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		16a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		16b. KIND OF BUSINESS OR INDUSTRY					
Westminster		3614 Ridge Rd.		School teacher		Retired					
17a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		17b. STATE		17c. COUNTY		17d. CITY OR TOWN		17e. INSIDE CITY LIMITS?		17f. STREET ADDRESS	
Md. 21157		Carroll		Westminster		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				3615 Ridge Road	
18. FATHER'S NAME		19. MOTHER'S MAIDEN NAME		20. INFORMANT		21. ADDRESS					
Ernest R. Franklin		Clara H. Koontz		Edward W. Will, Jr.		Westminster, Md.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		21. ADDRESS					
No		220-36-9633A		Edward W. Will, Jr.		3239 Ridge Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CVA</u> 4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ASVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASVD</u> DUE TO, OR AS A CONSEQUENCE OF PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 8/24, 1982, to 11/11, 1982, that (I) (we) lost saw the deceased alive on 11/8, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
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